DOCUMENT RESUME

ED 222 003 EC 150 071

AUTHOR	Wnek, Linda; And Others
TITLE	Parent Infant Program: Program Manager's Manual.
INSTITUTION	Ohio State Univ., Columbus. Herschel W. Nisonger Center.
SPONS AGENCY	Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
PUB DATE	80
GRANT	G007700702
NOTE	180p.; These materials were developed by the Parent Infant Project (Early Infant Intervention through Parent Interaction).
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	*Child Rearing; *Developmental Disabilities; Developmental Programs; *Home Programs; Individualized Education Programs; Infants; Interdisciplinary Approach; Models; *Parent Child Relationship; *Parent Education; Program Descriptions; Program Development; Program Evaluation; Student Evaluation; Teamwork
IDENTIFIERS	*Parent Infant Program

ABSTRACT

The document consists of a program manager's manual for the Parent Infant Program (PIP), an early intervention program designed to foster effective parenting of infants with developmental disabilities and delays. Section 1 provides a program overview. Three program goals are: to build parental confidence as primary teachers/facilitators of their infant's development; to foster effective interactions between parent and infant which promote mutual feelings of competence and enjoyment; and to provide information, support, and assistance to parents in dealing with needs associated with having a developmentally delayed infant. An individualized developmental program geared toward the needs of the infant and the family is developed, implemented, and monitored by program staff. The model involves an initial assessment, program planning, ongoing home programing and monitoring, and periodic review and evaluation phases. Section 2 focuses on the role of the team in the PIP model. The multidisciplinary team provides the vehicle through which program managers can enhance or develop their skills in the areas of infant programing and working with parents. A third section describes the purpose and procedures for initial assessment in the areas of gross motor, fine motor, cognitive development, language development, and social development. Section 4 presents the second phase of the program--program planning--which involves developing a treatment program by synthesizing and integrating information obtained during the initial assessment, obtaining parental priorities and concerns for their infant's programing, developing an individualized program plan, and summarizing initial assessment results and plans in a report. A fifth section on ongoing home activities covers guidelines for writing home activities, considerations in developing a home program, and resources used in development. A final section addresses the purpose and procedures for periodic review and evaluation. Among appendixes are self evaluation questions for the professional working with parents, a report on child development, and an annotated bibliography. (SW)

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PROGRAM MANAGER'S MANUAL

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and
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These materials were developed by the Parent Infant Project (Early Infant Intervention Through Parent Interaction) with funds provided by the Bureau of Education for the Handicapped, Grant #G007700702. The views presented are those of the authors and do not necessarily represent the official position of the Bureau of Education for the Handicapped of the Department of Health Education and Welfare.

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1980

PARENT INFANT PROJECT

(EARLY INFANT INTERVENTION THROUGH PARENT INTERACTION)

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ACKNOWLEDGEMENTS

The ideas and materials in this manual reflect the input of many people with whom the Parent Infant Project staff interacted over the three years of operation. In particular, acknowledgements are due:

To Dr. Dorothy Hutchison, who conveyed the values of adult education and the team approach in working with families of handicapped infants.

To Dr. Rose Bromwich, whose input brought new direction to the Parent Infant Program model and provided the impetus for the PIP focus on the parent-infant interaction in fostering effective parenting of the handicapped infant.

To the faculty and staff of Nisonger Center and The Ohio State University who volunteered their time and input to the Parent Infant Program. Particularly to Lynn Allen and Deborah Arms, who gave freely of their time and their expertise to the families and students served by the Parent Infant Program.

And, finally, to the many dear families who participated in the Parent Infant Program and provided invaluable input to the development of a model for serving infants with developmental disabilities that is sensitive to the needs of the family.

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SECTION

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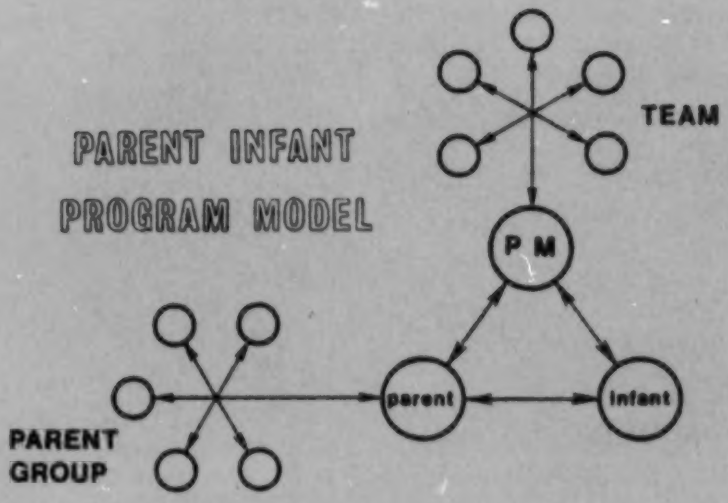


PARENT INFANT PROGRAM OVERVIEW

THE PARENT INFANT PROGRAM

BACKGROUND

The Parent Infant Program is an early intervention program designed to foster effective parenting of infants with developmental disabilities and delays. The key questions addressed in this section are:

- What is the Parent Infant Project?
- Who does the Parent Infant Program serve?
- What are the Parent Infant Program goals?

WHAT IS THE PARENT INFANT PROJECT ?

The Parent Infant Project was funded July 1, 1977 by the Bureau of Education for the Handicapped of the Office of Health, Education, and Welfare. The project was one of over 200 programs across the country funded by the Bureau under the Handicapped Children's Early Education Program.

During the three years of funding, the project has:

- Developed a program model for serving handicapped infants,
- Demonstrated that program, and
- Disseminated and replicated the model program.

WHO DOES THE PARENT INFANT PROJECT SERVE ?

While most Bureau of Education programs in the Handicapped Children's Early Education Program network are designed to serve children of preschool and early school-age, the Parent Infant Program is designed to provide services to parents and their infants from birth to three years.

As an "early" intervention program for infants, the Parent Infant Program's criteria for eligibility varies in some respects from that of programs serving

older children. Unlike programs for the older child with a diagnosed or clearly identified developmental problem, the infant program seeks to identify and serve infants who have developmental lags or who are at risk for later disabilities. Many developmental disabilities are not diagnosed until the child is older and yet, many early indicators of developmental problems may be present and observed by both parents and physicians. Thus the Parent Infant Program, in recognizing the need for early assistance to parents and infants, and yet realizing the detrimental effects of early labelling, aims at identifying infants on two levels:

1) Infants with a clearly identified and/or diagnosed developmental problem (e.g., Down's Syndrome, where risk is established); and

2) Infants at risk for later developmental disabilities, often having histories of prenatal, perinatal, neonatal, and early developmental events involving damage to the developing nervous system. (This second category also includes infants showing delay or abnormality in early development where there is no apparent cause.)

WHAT ARE THE PARENT INFANT PROGRAM GOALS ?

The ultimate goal of the Parent Infant Program is to foster effective parenting of infants with developmental disabilities or delays. Effective parenting is parental behavior which promotes a parent-infant relationship within which there is mutual satisfaction and enjoyment as well as the enhancement of the competence and self-esteem of both parent and infant.

The Parent Infant Program is not merely an "infant stimulation" program, although effective facilitation of infant development is an important program goal. Rather, to provide for the needs of the infant most effectively, the Parent Infant Program focuses primarily on the parents. This underlying program philosophy is based on several basic beliefs.

1) Parents are the most effective facilitators of their infant's development. The infant depends almost entirely on his parents and family members for the experiences that he will have during his early life. Indeed, it is the parent who mediates the environment for the young infant. In the security of the first relationship with his parents, the young infant develops a growing competence and mastery over his environment. Therefore, effective facilitation of infant development can be logically accomplished through the primary caretakers.

2) The mutually rewarding parent-infant relationship is one in which the optional development of both infant and parent is enhanced. For the parent of the infant with a developmental disability, a mutually rewarding relationship may, at first, develop more slowly. This may occur because:

   - Initial disappointments and feelings of parents regarding their new infant may temporarily interfere with their initial ability to derive satisfaction from interactions with their infant, or

   - Characteristics of the infant (e.g., his temperament or the nature of his developmental problem) may make it more difficult

for the parent and infant to develop a satisfying relationship and/or may shake the parents' confidence in their own ability to parent their infant.

3) Parents of infants with developmental problems have needs outside those that relate directly to the facilitation of their infant's development. In the past, most programs focused almost exclusively on the infant's problems, working with the parent only to the extent that they could assist in the remediation of these problems. Parents, during the early years of their infant's life, often need considerable support, information, and assistance in their efforts to make adjustments and re-establish equilibrium in their lives and family. Many of the fears parents have may stem from a lack of understanding or knowledge of their infant's problem. Feelings of isolation and guilt may be alleviated by other parents and professionals who can provide empathetic support and assistance.

From what is known about the early parent-infant relationship, it seems not only safe, but appropriate, for early interventionists to perceive the needs of the infant as the core of parental needs. Therefore, the Parent Infant Program goals do not artificially separate the infant from the parent, but treat them in many ways one and the same.

To achieve the ultimate program goal, or, to foster effective parenting of infants with developmental disabilities and delays, three program goals guide the program activities. These are:

1) To build parental competence as primary teachers/facilitators of their infant's development which, in turn, will facilitate maximum child development;

2) To foster effective interactions between parent and infant which promote mutual feelings of competence and enjoyment; and

3) To provide information, support, and assistance to parents in dealing with needs associated with having an infant with a developmental problem.

Finally, in trying to work towards these goals, it is important to recognize the delicate balance of the healthy or optimal relationship (i.e., the balance between being a responsive parent and a good teacher). At times, in the efforts to build parental competence as "teachers" of their infants, we may inadvertently effect the basic affective relationship that is so critical to the optimal development of the infant. Parents may be good teachers, good facilitators, knowing well the techniques and activities suggested by the professional, but they may not enjoy their interactions with their infant. Therefore, an underlying aim of the Parent Infant Program is to assist parents in maintaining a healthy balance of interactions with their developing infant.

THE PARENT INFANT PROGRAM MODEL

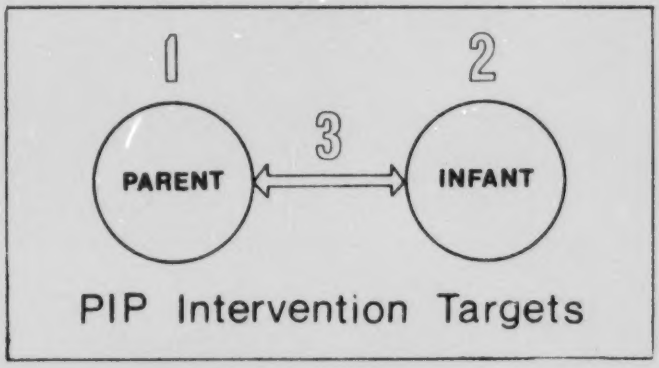
The Parent Infant Program Model is an approach to early intervention which attempts to address the complex needs of the family with an infant with a developmental problem. Consistent with its three program goals, the Parent Infant Program Model is designed to impact on the:

1) Parent,

2) Infant, and

3) Parent-Infant Interaction.

This section describes the two major program components which are designed to respond to the specific needs of each target area depicted in the figure below.



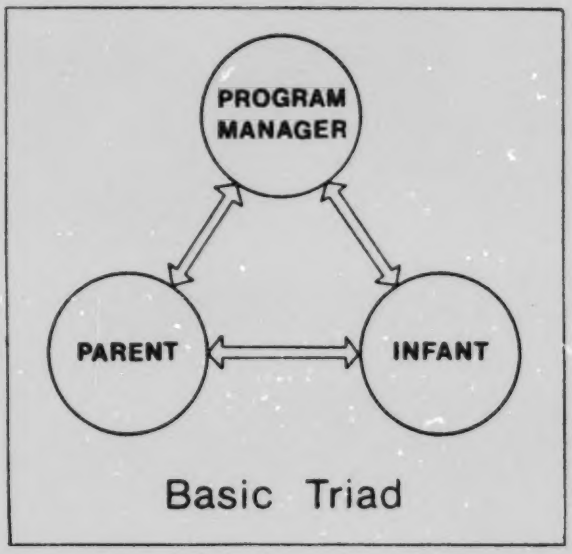
The key issues addressed in this section are:

- What is the role of the Developmental Classes?
- What is the role of the Parent Group?
- What is the Parent Infant Program Model?

WHAT IS THE ROLE OF THE DEVELOPMENTAL CLASSES ?

Typically, the primary reason most parents seek out an early intervention program is to get help for or learn to help their infant. The Developmental Classes are designed to assist parents in their role as primary facilitators of their infants' development. An individualized program geared toward the needs of the infant and family is developed, implemented, and monitored by program staff. In addition, the parents are assisted in becoming an integral part of the process and a contributing member of a team. While most programming is actually carried out by the family in the home during the week, initial and ongoing planning and instruction is carried out in the weekly Developmental Classes.

In the Developmental Classes, each family works with one professional of a specific discipline. This person, the primary contact with the parents throughout the program, is called the program manager. The program manager, the parents, and the infant constitute the basic triad of the Developmental Classes as depicted in the figure below.

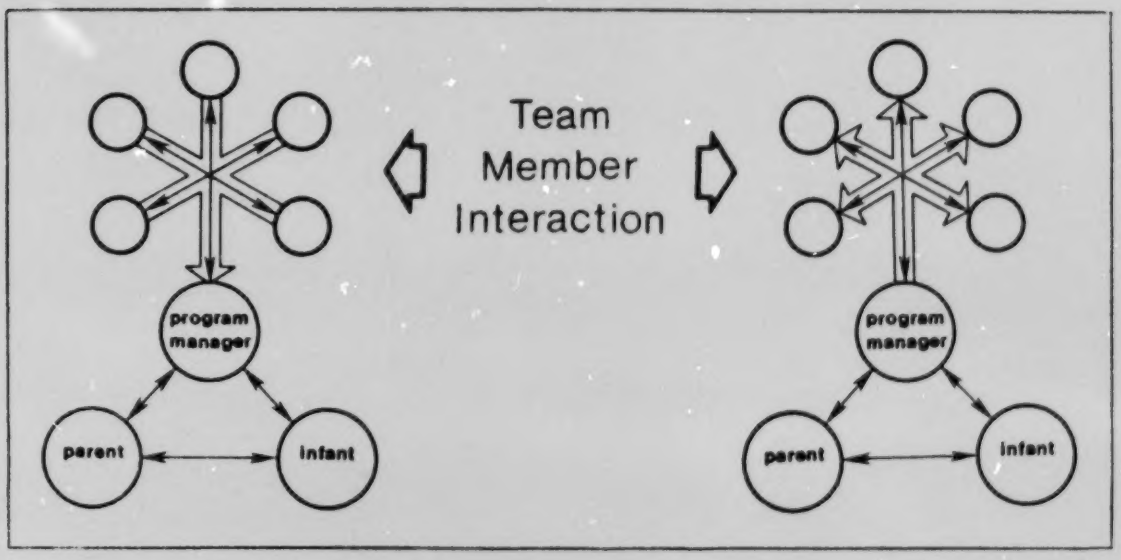


Basic Triad

In working with the family, the line of communication and input is two-way. Parents as well as infant provide basic information to the program manager and, in turn, draw on the program manager for assistance in identifying needs and developing a home program for their infant. In that the Parent Infant Program is a group program, each Developmental Class is comprised of up to six families with their respective program managers.

In order to provide the multidisciplinary input needed for quality, well-rounded programming for the family and to minimize disruption and discontinuity to the family, a team approach is essential to the Parent Infant Program Model. The team concept is easily implemented and effective. In each Developmental Class, each program manager working with a family represents a specific discipline. Collectively, the program managers on a given team represent a variety of disciplines, backgrounds, and experience. Each team is usually comprised of some combination of the following disciplines: physical and occupational therapy, nursing, psychology, special education, child development, and speech/language. In many cases, knowledge of infant development overlaps disciplines. Therefore, not all disciplines are necessary for a well-rounded team. In the Developmental Classes, the team serves the necessary function of a resource to all components of the basic triad.

The team approach is a two-way process. The program manager draws from the team to provide quality input to the family. He/she coordinates all input from the team and communicates this information to the family. Conversely, as a member of the team, the program manager provides discipline input to other members of the team which in turn filters through to other families in the Developmental Class. The two-way nature of team interaction in the Developmental Classes is depicted at the top of the next page.

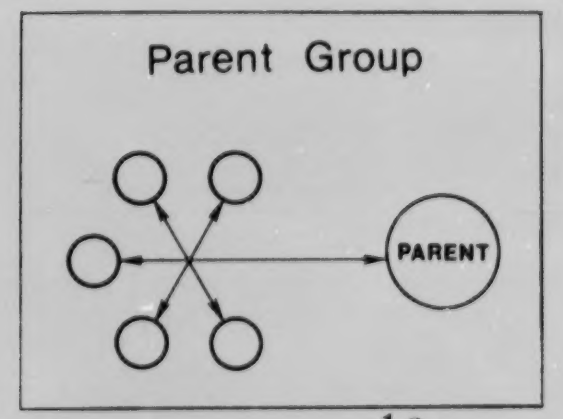


In the Developmental Class, three basic roles can be identified, that of the parent (representing the infant), the program manager, and the team. Each of the three contributing parties, in fulfilling their respective roles, has the responsibility to:

- Clarify/communicate/question,
- Observe,
- Assist,
- Input,
- Follow through, and
- Learn.

WHAT IS THE ROLE OF THE PARENT GROUP ?

The Parent Group is made up of all of the parents assigned to a particular team of program managers.



Although the parent is the primary recipient and contributor in the Developmental Classes, the primary focus is on the needs of the infant. In the Parent Group, emphasis shifts to parent needs for support and information, even though these concerns most often center around the infant. Just as the team is the primary resource for the development of a program for the infant in the Developmental Classes, the Parent Group is a resource for the parent for emotional support and information.

In many ways the Parent Group compliments the activities of the Developmental Classes. The Parent Group is designed to meet two basic needs of parents:

1) The need for support, and

2) The need for information.

It is felt that meeting these needs will foster more effective parenting which is, of course, the ultimate goal of the Parent Infant Program.

SUPPORT

Support is primarily provided by other parents. The group is designed to provide opportunities for parents to share and discuss common experiences and concerns as parents of an infant with a developmental disability or delay. For example, this might include experiences with doctors and other professionals, coping with day to day situations and dealing with reactions of relatives, friends, and the community.

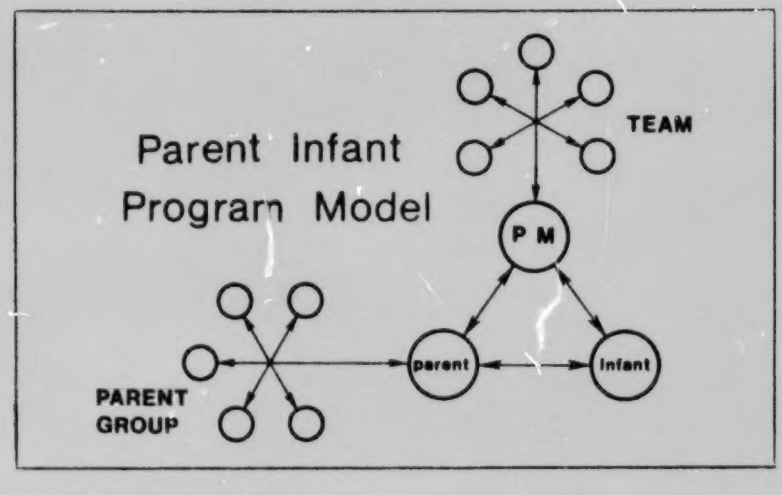
INFORMATION

Much of the parents' need for information is also satisfied by other parents. In addition to this type of group information sharing, more formal information sharing is also a part of the Parent Group. To meet specific information needs identified by the group, special information sessions are planned throughout the program year by the group facilitator (PIP staff) and by the parents themselves. These can include information which is designed to acquaint parents with community resources such as school programs, day care, and parent advocacy groups. This type of information is generally provided by the agency personnel. Information concerning the developing infant (e.g., communication, gross motor development, etc) is generally provided by the Parent Infant Program staff or by guest speakers.

Parents are involved in planning topics for group discussions. Therefore, the specific schedule of activities varies according to the needs and interests of each Parent Group.

WHAT IS THE PARENT INFANT PROGRAM MODEL ?

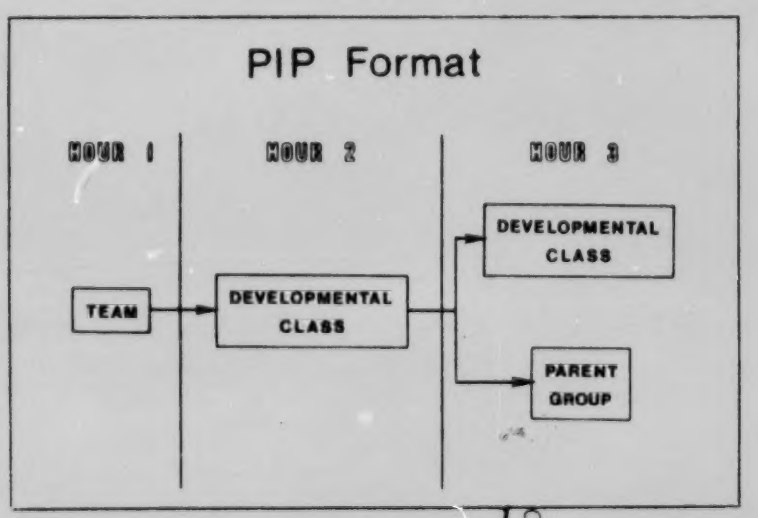
As you will recall, the Parent Infant Program Model is an approach to early intervention which attempts to address the complex needs of a family with an infant with a developmental problem. The figure at the top of the next page is a graphic representation of the Parent Infant Program Model. Note that



the parent, infant, and program manager triad constitutes the core of the model. The Developmental Classes and Parent Group represent the two major implementation strategies used in the program. Through the Developmental Classes, the parents, infants, and program managers draw from a team representing various disciplines to develop and implement ways to foster infant development and more effective parent-infant interaction at home. In the Parent Group, a supportive milieu is provided for open interaction among parents sharing common concerns and interests. In the group, needs of the parents are the primary emphasis.

THE PARENT INFANT PROGRAM FORMAT

The Parent Infant Program is a weekly program. It is held during evening hours to encourage both mothers and fathers to take an active role in their infant's development. While families come for two hours each week, the Parent Infant Program is actually a three hour program as depicted in the figure below.



Following is a brief description of the specific activities which take place during each of the three hours.

WHAT HAPPENS DURING THE FIRST HOUR ?

During the first hour, team members (i.e. the program managers, PIP staff, and other consultants) meet to address needs and review programming for individual families in the Developmental Class. Each program manager seeks assistance from other disciplines and provides input to other program managers. Specific plans are made for working with families in the following hour. Arrangements are made for other program managers to interact with the family or infant when needed either during the second or third hour. The first hour, then, is devoted primarily to team functions which vary depending upon the phase of the program.

Also, during the first hour, more formal inservice activities may be scheduled in which specific information is shared with the team as a group which will upgrade skills in working with families. Inservices can be offered by a PIP staff member, program manager, or an outside consultant.

WHAT HAPPENS DURING THE SECOND HOUR ?

The Developmental Class is held in the second hour. During this hour, the program manager, parents, and infant work together on assessment, planning, or home programming (depending on the phase of the program). Each triad works individually, drawing on other team members as necessary and planned during the first hour staffing.

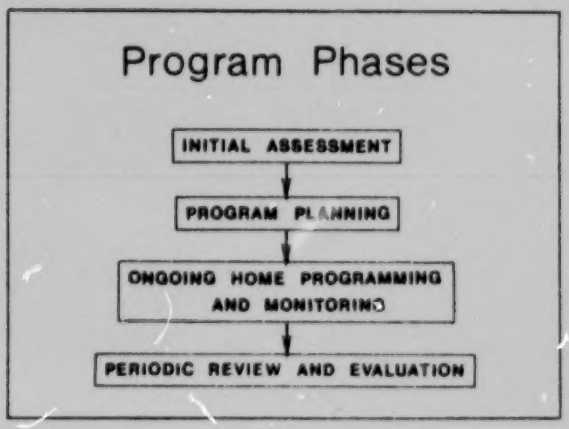
WHAT HAPPENS DURING THE THIRD HOUR ?

During the third and final hour of the program, two activities are carried out simultaneously. They are,the Parent Group and Developmental Classes. Parents leave their infants with program managers in the Developmental Class and meet together in the Parent Group. In the Developmental Classes, interaction among team members is emphasized. Program managers and PIP staff provide discipline input to other program managers when requested. The third hour offers the opportunity for program managers to interact with, handle and observe other infants in the class for future reference in the team meetings.

THE PARENT INFANT PROGRAM PROCESS

In providing services to parents and infants in the Parent Infant Program, a specific sequence of procedures or steps are followed. These steps are referred to as program procedures. They are carefully designed to assist in the program process, that is, the process through which individualized activities and assistance (or program) are developed and implemented to meet the needs of the family and to accomplish the overall goals of the Parent Infant Program. While these program procedures are flexible and amenable to the individualized needs of the family, they serve as a fairly standard set of guidelines for the efficient and effective implementation of the Parent Infant Program.

The Parent Infant Program process can best be described within the four major phases depicted below.



The key questions addressed in this section are:

- What happens in the initial assessment phase?
- What happens in the program planning phase?
- What happens in the ongoing home programming and monitoring phase?
- What happens in the periodic review and evaluation phase?

WHAT HAPPENS IN THE INITIAL ASSESSMENT PHASE?

During the initial assessment phase, the needs of the family are identified. Through the initial home visit, an initial identification of what the family perceives as their needs can be made. To assess the developmental needs of the infant, a comprehensive, two step, initial assessment is carried out. This assessment involves both initial structured observations of the infant by both parents and staff to determine "how" the infant interacts with his environment and to determine "what" specific skills the infant has mastered using a norm-referenced developmental assessment. Parental needs for informa-

tion and support are assessed both in the home visit and the initial sessions of the weekly Parent Group. The accurate assessment of parent and infant takes on primary importance in the Parent Infant Program process in that it determines much of the quality of the ensuing program. All of the best resources can be brought to bear on a program that still misses the mark because it is not "responsive" to the needs of the family and/or infant.

WHAT HAPPENS IN THE PROGRAM PLANNING PHASE ?

Program planning is based on information gathered during the initial assessment phase. During the program planning process, goals are established and prioritized by both parents (in the Parental Goals and Recommendations) and staff (in the Programming Recommendations). Initial planning is formalized in the development of an Individualized Program Plan (IPP) which specifies an initial plan of action for involvement in the Parent Infant Program.

WHAT HAPPENS IN THE ONGOING HOME PROGRAMMING AND MONITORING PHASE ?

Ongoing home programming and monitoring is carried out throughout the program year. Initial plans are refined and carried out and ongoing review of the infant's status is monitored weekly during the Developmental Classes. Home activities, home visits, and supplemental services are provided which are aimed at accomplishing specific objectives for the infant's development. As the infant and family develop, new objectives are established.

WHAT HAPPENS IN THE PERIODIC REVIEW AND EVALUATION PHASE ?

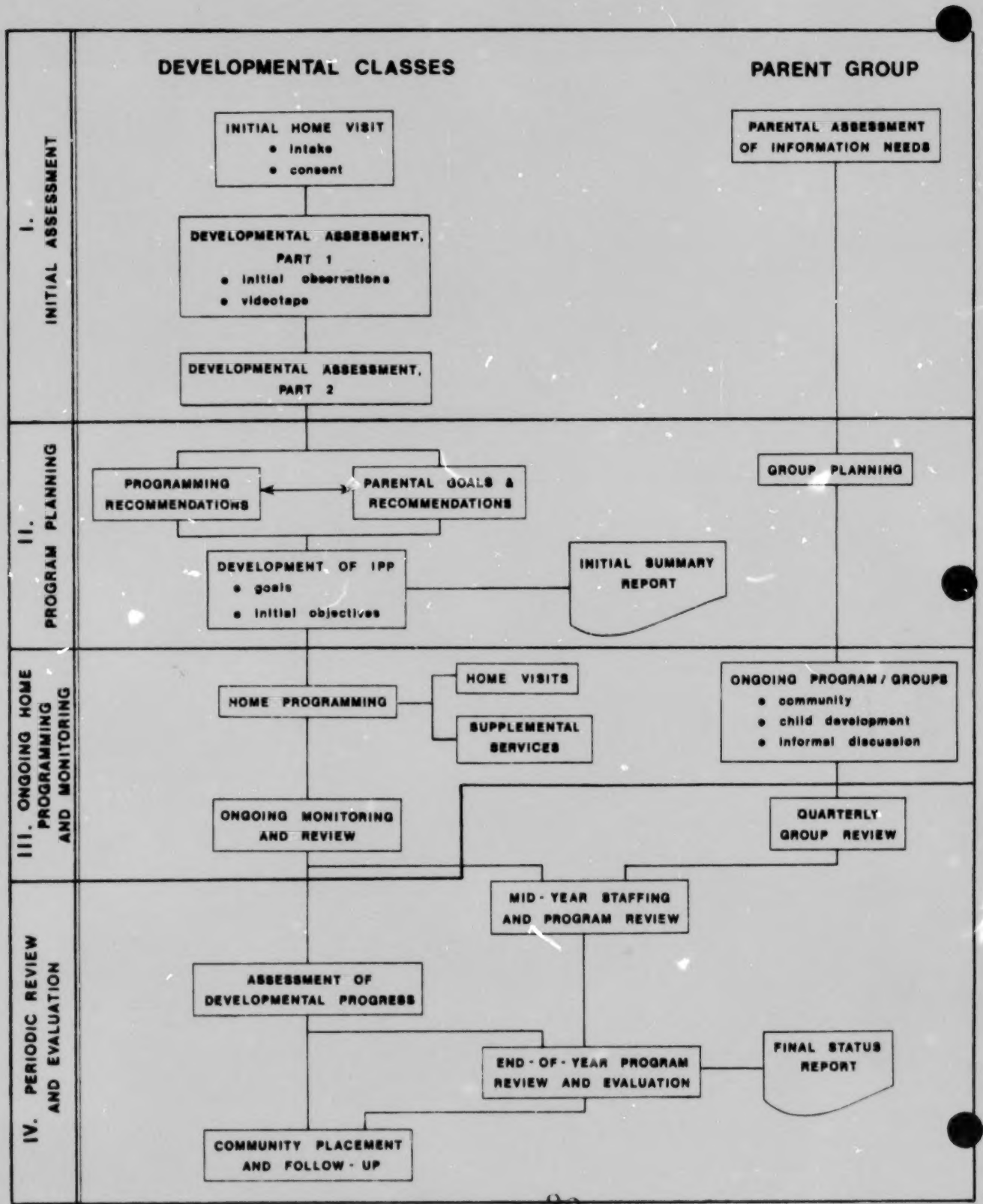
Finally, while program review and revision is ongoing throughout the year, formal review and evaluation is planned on a periodic basis. Periodic review and evaluation is accomplished at mid-year through a mid-year staffing attended by parents and program staff, and again at the end of the program year. The mid-year review focuses on evaluation of the infant's past programming received in the Parent Infant Program and the revision of program plans where necessary for the remainder of the year. End-of-the-year evaluation includes:

- Determination of infant developmental progress through re-administration of the norm-referenced developmental assessment, and
- Parent evaluation of their participation in the Parent Infant Program.

The final evaluation provides information which is also useful to other community programs in which the child may be involved.

The figure on the next page summarizes the activities described for each of the major program phases.

PARENT INFANT PROGRAM PROCESS



THE ROLE OF THE PROGRAM MANAGER

The individual selected as a program manager plays a key role in the Parent Infant Program Model. He/she not only assumes primary responsibility for the planning and monitoring of a parent-delivered program for one particular family, but also functions as a disciplined member of a transdisciplinary team.

In this section, the following questions are addressed:

- What special skills and competencies are required of program managers?
- What types of training are required?

WHAT SPECIAL SKILLS AND COMPETENCIES ARE REQUIRED OF PROGRAM MANAGERS ?

The program manager role requires a wide range of skills in the areas of infant assessment, infant programming, parent education, interpersonal interactions with parents, and team participation or membership. A comprehensive competency listing follows including each of these skill areas. Throughout your participation in the Parent Infant Program program managers should strive to develop and enhance their skills in each of the areas cited.

INFANT ASSESSMENT

1) Assess how individual infants deal with and learn from their daily life situations.

2) Assess delayed infant's performance across developmental areas.

3) Assess how parents and infants interact and affect each other's responses.

4) Use the results of assessments to set priorities and target objectives for individual programs.

INFANT PROGRAMMING

1) Write clear and precise behavioral objectives as targets for programming.

2) Write appropriate home activities corresponding to target objectives.

3) Monitor and document infant progress.

4) Be familiar with a variety of programs and materials useful in infant programming.

PARENT EDUCATION

1) Assist parents in understanding intervention strategies and individual programming for their infants.

2) Involve parents as key members of a programming team for their infant.

INTERPERSONAL INTERACTIONS WITH PARENTS

1) Establish relationship built on mutual respect, not equality.

2) Be an active, empathetic, objective listener, able to accept parental opinions without passing judgment on them.

3) Be sensitive to unspoken indicators of parents' feelings and needs.

4) Be aware of the stages of adjustment that parents of handicapped infants experience and that much of the parents' reactions are based on human nature which is automatic, instinctive, and unconscious rather than intentional.

5) Use parents' terminology and level of conversation in contacts.

6) Reinforce parents' strengths and build on these to motivate growth or change.

7) Be sensitive to intra-family relationships and the infant's role in the family.

8) Help parents to accept their infant as an individual. Emphasize sequence of development rather than "normal" developmental levels when programming.

9) Assist parents in developing a program of positive action for their infant and family.

TEAM SKILLS

Team skills are listed on page 2-9 of your notebook. They encompass all of the communication and interactive skills required for effective participation in a team.

WHAT TYPES OF TRAINING ARE REQUIRED ?

In order to adequately train program managers to perform their roles effectively, a series of preservice workshop sessions are required prior to actual involvement with families. Preservice activities are designed to accomplish four related goals:

1) To provide a basis of information and the rationale necessary to carry out the Parent Infant Program procedures;

2) To provide an opportunity for practical application of this knowledge base prior to working with families;

3) To increase awareness and sensitivity to families having infants with developmental problems; and

4) To stimulate motivation and interest in fulfilling the responsibilities of the program manager role.

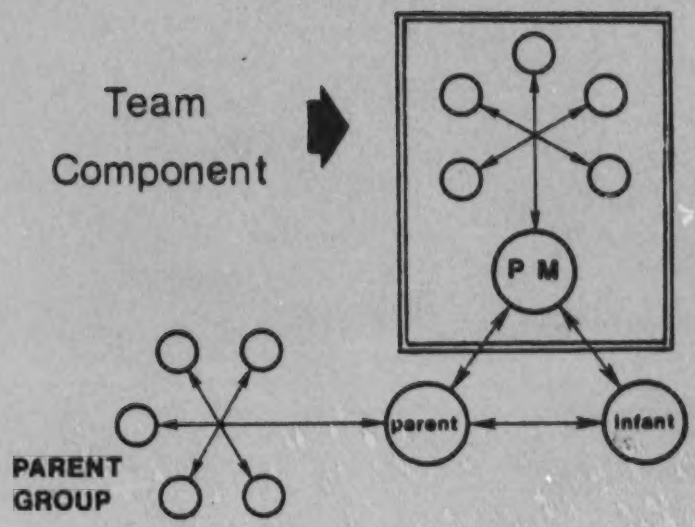
In addition to the initial preservice activities, a series of inservice sessions are provided for the duration of the program. Initially, these inservices focus on ongoing programming information supportive of that presented during preservice. As program managers become more proficient in their roles, inservice activities are focused on providing more specialized information aimed at meeting needs identified by team members (e.g., sensormotor assessment, handling, language stimulation, vestibular stimulation). The later type of inservice is often presented by program managers having specific areas of expertise.

Because of the need for continuity of services, program managers are asked to give a full year of service (the average duration of program for any one family).

PARENT INFANT PROGRAM

SECTION

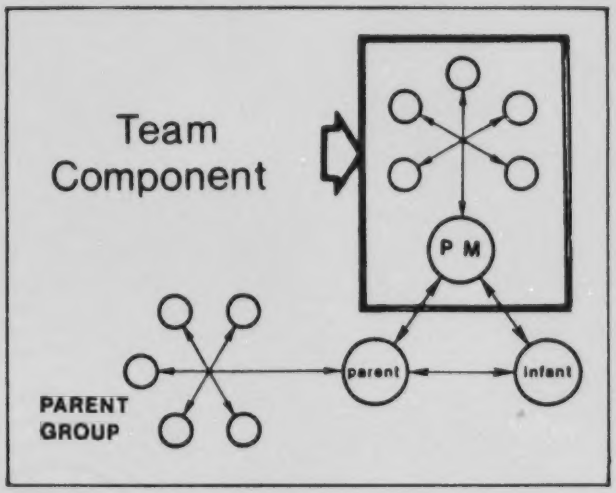
2



THE PIP TEAM APPROACH

THE ROLE OF THE TEAM IN THE PIP MODEL

As you can see in the figure below, the team constitutes a vital component of the Parent Infant Program Model.



The key questions addressed in this section are:

- Why is the team component included in the Parent Infant Program Model?
- How does the team concept work?

WHY IS THE TEAM COMPONENT INCLUDED IN THE PARENT INFANT PROGRAM MODEL?

The team component was included in the Parent Infant Program Model to:

- Minimize disruption and discontinuity by assigning one contact (i.e., program manager) to each family; and
- Provide multidisciplinary expertise to ensure quality, well-rounded programming for each family.

Although it is highly desirable for each family to have a single primary contact, no individual program manager has expertise in all of the areas required for comprehensive, effective programming. The team component of the Parent Infant Program Model provides each program manager with access to expertise from all relevant disciplines in planning and implementing his/her family's program.

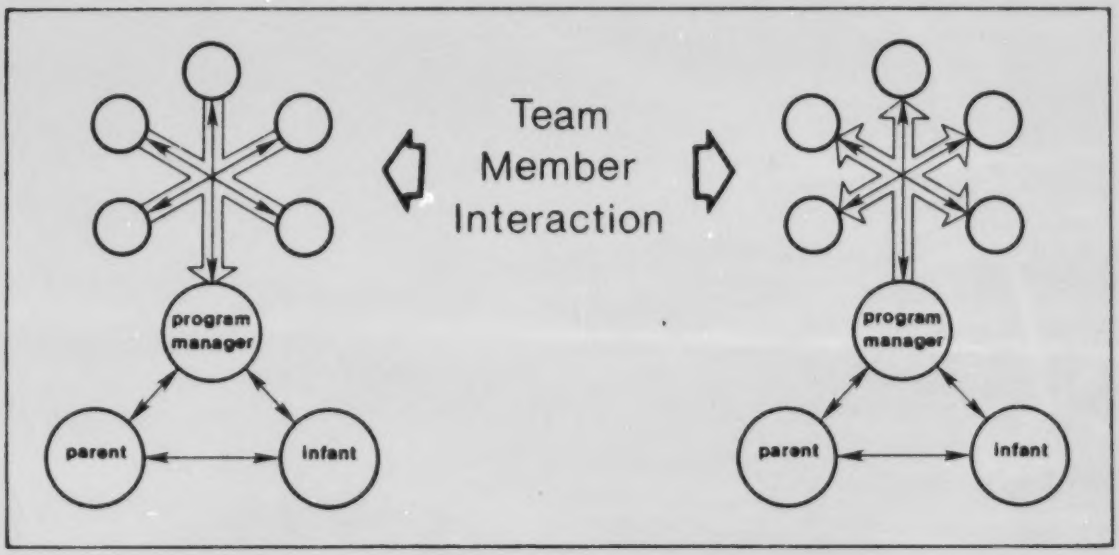
The particular expertise of each program manager is considered when assigning families. The needs of the infant and family are matched with the primary expertise of the program manager.

HOW DOES THE TEAM CONCEPT WORK?

A team consists of three to five program managers from various disciplines. Each team should represent a well-rounded cross-section of disciplines pertaining to infant development (e.g., psychology, speech and language, physical and occupational therapy, child development, special education, and nursing).

Although each team member has primary responsibility for one family, as a team member, he/she shares responsibility for programming all infants and families assigned to the team. As depicted in the figure below, the team approach is a two-way process in that each program manager:

- Draws from the team to provide quality input to his/her family, and
- Provides disciplinary input to other members of the team.



The team is also an important vehicle for developing the skills of each team member in relation to early intervention programming. Through team discussion and sharing of ideas and expertise, members gain knowledge and appreciation of the contributions of various disciplines to infant programming and expand their own knowledge and skills.

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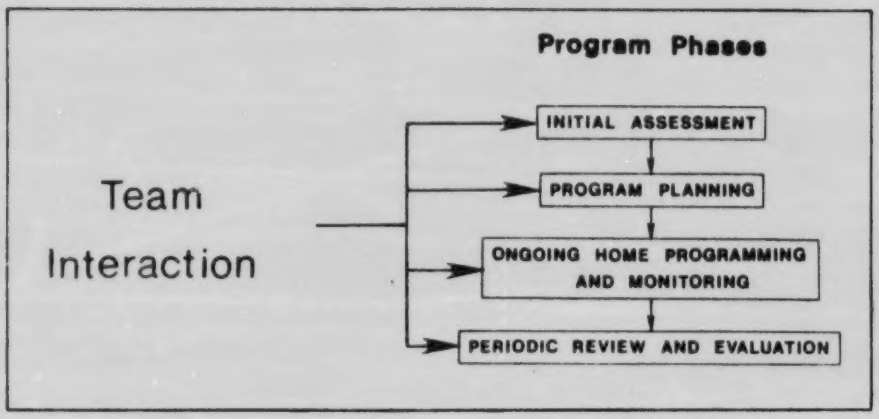
* See Appendix/Glossary for a brief description of disciplines typically involved in early intervention.

THE ROLE OF THE TEAM THROUGHOUT THE PARENT INFANT PROGRAM PROCESS

The team plays an important role in each of the four phases of PIP programming as depicted in the figure below.



The key questions addressed in this section are:

- What role does the team play in the initial assessment?
- What role does the team play in program planning?
- What role does the team play in ongoing home programming and monitoring?
- What role does the team play in periodic review and evaluation?

WHAT ROLE DOES THE TEAM PLAY IN THE INITIAL ASSESSMENT ?

Program managers assist each other in conducting the initial developmental assessment. An early team meeting may be used to discuss interpretation of items on the assessment and why certain items are included. This is particularly important if team members are relatively unfamiliar with the assessment instrument. Team members should agree on the way they interpret and assess the items since they will be involved with all the families assigned to the team. They can be of help to each other in interpreting items from the areas related to their discipline training.

During the team meeting, program managers can make arrangements to assist each other with the actual assessment of their assigned infant. Team members with expertise in motor development may, for example, assist and consult with team members with backgrounds in communication and cognitive development or visa-versa.

Immediately following the assessment, program managers need to summarize the results and share them with other team members. They can assist each other in recognizing the relationship of developmental milestones to each other, particularly as they crosscut developmental areas. This can be done by listening closely to each other's presentations and making observations of the relationship of skills across discipline areas. Program managers will have varying degrees of expertise in summarizing assessment results in different developmental areas. They can learn more about all developmental areas by listening to each other.

WHAT ROLE DOES THE TEAM PLAY IN PROGRAM PLANNING ?

Program managers ask for and offer suggestions to each other on goals and objectives based on the assessment results. They can be helpful to each other in determining how much progress to expect from a particular infant in specific developmental areas, that is, not presuming too much (or too little) from the infant's present level of skill.

Discussion among team members regarding goals and objectives begins at team meetings prior to the program planning conferences. Program managers attend the program planning conferences for the families assigned to the team. At these conferences, program managers contribute and respond to the ideas and questions of the parents and others from their particular discipline perspective. Although discussion prior to the planning conference may have resulted in agreement among team members, honesty with the parents demands that any remaining differences are discussed rather than hidden. Hopefully, an open discussion will result in the best program plan for each particular infant and family.

WHAT ROLE DOES THE TEAM PLAY IN ONGOING HOME PROGRAMMING AND MONITORING ?

Throughout the ongoing developmental classes, team meetings are used for consultation among program managers regarding programming questions and concerns (including suggestions for new activities to achieve goals). Program managers need to keep each other up-to-date on the status of the programming for each infant and family assigned to the team. Plans for specific observations of each other's infant may result from team discussion. In addition, a result of specific programming concerns that are identified, program managers may plan and participate in in-service sessions designed to strengthen team memebr skills.

WHAT ROLE DOES THE TEAM PLAY IN THE PERIODIC REVIEW AND EVALUATION ?

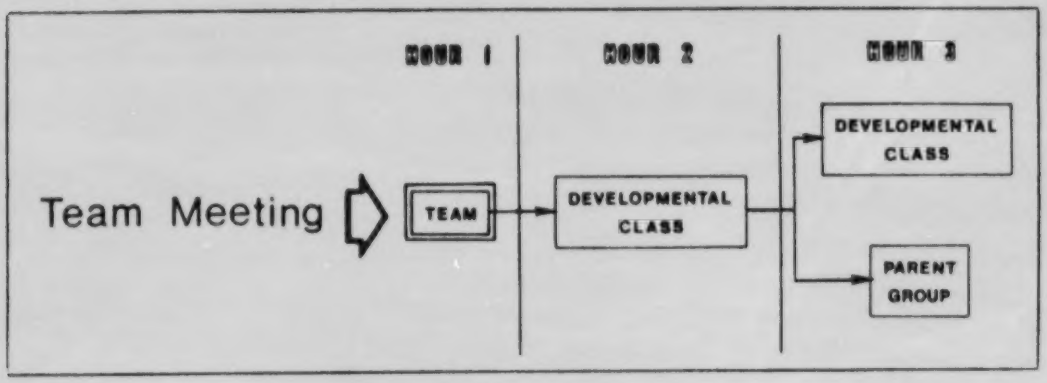
Program managers attend mid-year staffing and program review conferences of the families assigned to the team. They share with the parents their observations of the infant's progress and contribute to discussions of programming

concerns and revisions or additions to goals and objectives.

Program managers assist one another in the end-of-the-year developmental assessment in the same manner as they did with the initial assessment. Team members may also discuss recommendations to make to the parents for enrollment in subsequent early intervention programs.

TEAM MEETINGS

Formal team meetings take place during the first hour of the weekly Parent Infant Program as shown below.



The key questions addressed in this section are:

- What is accomplished in the team meetings?
- What is the role of the team leader?
- How can the team leader facilitate team interaction?

WHAT IS ACCOMPLISHED IN THE TEAM MEETINGS ?

The specific issues addressed in the team meetings are a function of the specific program phase and program manager needs. The agenda is established by the team members and generally focuses on individualized programming for specific families or on in-service training.

INDIVIDUALIZED PROGRAMMING

In determining the agenda for a team meeting, team members generally begin by considering discussing a particular family's program. First priority should be given to an infant and family whose programming has presented difficulties. Alternately, a particular area of programming (e.g., gross motor development, communication skills, etc.) may be discussed for several families.

This discussion may be directed toward future programming concerns as well as present programming. As a result of team discussions, team members may decide to consult further with each other outside the formal meeting.

In summary, a team meeting may focus on providing team input for each infant and family's ongoing program by:

- Team problem solving concerning programming for a specific family,
- Keeping each other current on the objectives and activities of each infant and family, and
- Identifying needs for consultations between two or more team members (possibly to take place later in the evening's session).

IN-SERVICE TRAINING

Some meetings evolve around a topic related to early intervention programming. The topic should be decided on the basis of learning needs identified by the team members. The presentation should be made by an individual with a thorough understanding of the topic. If an individual with expertise is not available within the team, a nonteam member may be asked to give the presentation. The presentation should have a very practical orientation which is geared to applications in early intervention programming.

In summary, team meetings can develop team members' knowledge and skills by:

- Identifying the learning needs of team members,
- Sharing information related to these learning needs,
- Discussing issues related to early intervention programming,
- Presenting information on operational concerns such as the monitoring and documenting of infant progress, and
- Scheduling special topics.

WHAT IS THE ROLE OF THE TEAM LEADER ?

The team meetings are directed by a team leader. The role of the team leader is generally assumed by each of the team members in turn rather than assigned on a permanent basis to any one team member. This enables each program manager to learn team leadership skills.

Although the team leader must have a tentative agenda in mind for the team meeting, the main topics and discussions will most likely have been established by the team during the previous meeting. The agenda should be flexible enough to accomodate problems or concerns which are not apparent prior to the meeting.

HOW CAN THE TEAM LEADER FACILITATE TEAM INTERACTION ?

The major responsibility of the team leader is to facilitate productive discussion among team members and to model good team interaction. In addition, there are specific things a team leader can do to encourage more effective team interaction. The team meeting should consist of a give and take in which all members contribute rather than one person doing all the talking. In particular, the team leader must guard against assuming the role of expert on all questions brought up for discussion. Team members should not take a passive role. Following are some suggestions to help the team leader facilitate team interaction.

1) Encourage passive team members by:

   - Asking for their opinion on the topic under discussion, and
   - Commenting positively on their contributions.

2) Ask questions if team members do not seem to be explaining themselves well enough.

3) When a team member reports on an area of programming that is outside his discipline, encourage the team members of the appropriate discipline to respond.

4) If team leaders are not afraid to show their ignorance where it exists, the other team members will feel more comfortable in showing theirs. If everyone knew everything, there would be no need for the team!

5) Any questions that are asked of team members should be sincere.

6) Redirect conversation when the team meeting time is being used unproductively (e.g., for unrelated conversation or gossip).

7) Tactfully cut off a team member who is lecturing before you lose the entire group. One way of doing this is to ask another member to comment on what has been said.

8) Consider breaking into sub-teams for the latter part of the meeting if:

   - It appears to be a more effective way to handle needs for cross consulting, or
   - All general discussion has been completed.

9) Bring the meeting to a close if all members agree that all present needs have been covered. Do not try to prolong the meeting to fit an alloted time slot if all business is complete. By doing so, team members will be more willing to extend team meeting times when necessary.

TEAM MEMBER SKILLS

Working together as a team requires committment on the part of each member to develop the appropriate attitudes and interactive skills. It takes time for team members to learn to work together comfortably. How long it takes depends on the composition of the particular group and the skills that the team members bring with them. It is important for team members to get to know each other well enough so that they can admit both the strengths and weaknesses in their knowledge and skills and can give and accept help from others.

The key questions addressed in this section are:

- What communication skills should team members develop?
- What specific team skills should program managers strive to accomplish?

WHAT COMMUNICATION SKILLS SHOULD TEAM MEMBERS DEVELOP ?

A number of communication skills facilitate team member interaction. Following is a brief description of communication skills which all program managers should develop.

SUMMARIZING INFANT'S ABILITIES

A key speaking skill is being able to summarize an infant's present abilities. This also involves knowledge of major milestones in infant development so that appropriate emphasis is given specific skills. This helps in presenting a comprehensive, yet understandable, picture of the infant's development. Discipline jargon should be avoided.

CONTRIBUTING IDEAS

Each team member will need to learn to contribute their own ideas and suggestions to team members with varying degrees of familiarity with the concepts and issues. Speaking to professionals outside of one's own discipline generally involves a more detailed explanation of the assumptions underlying ideas and suggestions.

ASKING OTHERS FOR IDEAS

Sincerely asking for other team members' ideas and suggestions reflects an attitude that contributes to effective team functioning. Although this may seem very apparent, it is a difficult first step for professionals new to working as part of a team.

ASKING QUESTIONS

Team members need to ask questions to verify the meaning or implication of what another team member says. They must learn to listen closely to each other so that they are able to ask pertinent questions (i.e., those which have programming implications) regarding observations of an infant's performance.

REACTING

Commenting on each other's ideas and suggestions is important for productive discussions. Within the team, there will be times when members will hold different opinions. It is valuable to express these differences so that various options can be explored, and hopefully, the best decision reached. Team members need to learn not to be afraid of disagreeing with one another, while being tactful in expressing their disagreement.

WHAT SPECIFIC TEAM SKILLS SHOULD PROGRAM MANAGERS STRIVE TO DEVELOP ?

Following is a list of specific skills which program managers should strive to accomplish as members of a team. As you review this list, you may want to assess your own skill level in each area and determine target areas for improvement.

1) Recognize need for and seek input from other professionals.

2) Recognize value of and utilize ideas and suggestions from other professionals.

3) Encourage others to contribute their ideas and suggestions by your own attitudes and responses.

4) Recognize where one might be of help and offer help in a way that is perceived as helpful.

5) Communicate your professional knowledge and skills to others.

6) Listen carefully to perceive areas of agreement or disagreement.

7) Demonstrate initiation skills (e.g., start discussions, organize group, introduce new ideas, raise new questions, etc.).

8) Clarify discussion when needed by asking for additional information, requesting definition of vague terms, raising questions related to previous contributions.

9) Summarize or evaluate discussions when it will help the group work together productively.

10) Incorporate ideas of various members into a product acceptable to all.

11) Guide group discussion in role of team leader.

KEY POINTS

- *The team component of the Parent Infant Program Model is the mechanism through which each participant family receives comprehensive, multidisciplinary assistance with a minimum of discontinuity and disruption.*

- *The team provides the vehicle through which program managers can enhance or develop their skills in the areas of infant programming and working with parents.*

- *The team plays a critical communication and learning function throughout all phases of the Parent Infant Program.*

- *The ability of program managers to provide quality programming is, to a large extent, a function of their skills as a team member.*

- *Program managers should attempt to improve their team member skills.*

THINGS TO CONSIDER

1) What contributions do you feel you can make to your team?

2) What areas of support and assistance do you feel you will need from other members of the team?

FOR FURTHER INFORMATION

Consult the following publications for further information on the team approach used in the Parent Infant Program.

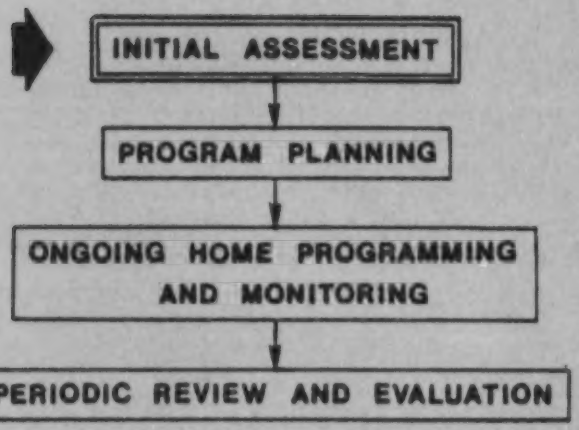
D'Wolfe, Lowry, Schilling, Siepp, Hutchinson. Staff Development Handbook - A Resource for the Transdisciplinary Process. New York: United Cerebral Palsy Association, 1976.

Hutchinson, D. A Model for Transdisciplinary Staff Development (Technical Report No. 8, The First Three Years: Programming for Atypical Infants and Their Families, Part I) New York: United Cerebral Palsy Association, 1974.

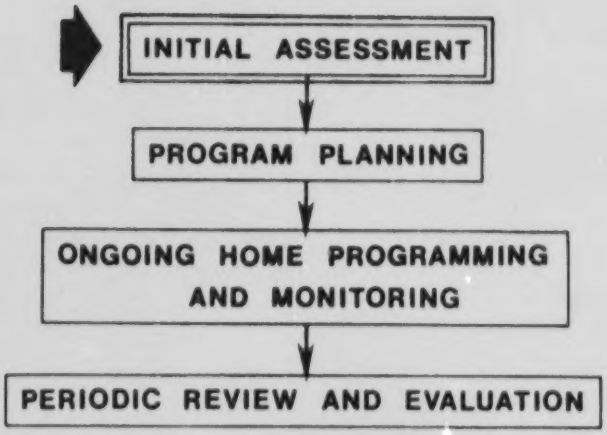
Hutchinson, D. "The Transdisciplinary Approach" in Mental Retardation: Nursing Approaches to Care. St. Louis, Missouri: CV Mosby, 1974.

SECTION

3



INITIAL ASSESSMENT



INTRODUCTION

The first, and perhaps most critical, phase in the Parent Infant Program process is initial assessment. Through the close observations of and cooperative interactions with the family which occur during this initial phase, the program staff can more accurately determine the needs of the infant, as well as those of the parent(s). It is only through a comprehensive and sensitive assessment of infant, parent, and family, that needs can be accurately assessed and a quality program planned. The information drawn from the initial assessment is the foundation upon which all subsequent work with the family is built. Thus, the importance of the initial assessment in the Parent Infant Program cannot be overestimated. It largely determines the degree to which the program is "responsive" to the needs of the family, or, the "quality" of the program. A thorough understanding of the purpose and nature of the steps involved in the initial assessment phase is, therefore, necessary for both program staff and parents.

THE ROLE OF INITIAL ASSESSMENT IN PIP

The key questions addressed in this section are:

- What is the purpose of the initial assessment?
- What is involved in assessment of the infant?
- What is involved in assessment of the parent-infant interaction?
- What is the purpose of the assessment of parent or family needs?

WHAT IS THE PURPOSE OF THE INITIAL ASSESSMENT ?

Recall that the overall goal of the Parent Infant Program is to foster effective parenting of infants with developmental disabilities or delays. To accomplish this goal, the Parent Infant Program aims at:

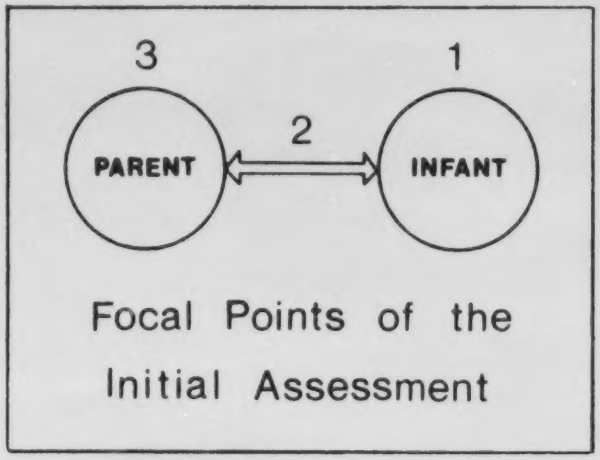
- Building parental competencies as primary facilitators of their infant's development;
- Fostering effective interaction between parent and infant which promote mutual feelings of competence and enjoyment; and
- Providing information, support, and assistance to parents in dealing with needs associated with having an infant with a developmental problem.

The initial assessment is the first step towards accomplishing these goals. In order to build parental competence as facilitators of development, we must first determine the needs of the infant and the existing skills of the parents. Similarly, in order to foster and reinforce effective and positive interactions between the parent and infant, we must be aware of:

- How the parent and infant interact,
- Contributions of each parent and infant to the interaction, and
- The effect that the interactional pattern has on both parent and infant.

And finally, to provide support, information, and assistance to parents which are responsive to their needs, we must increase our awareness and sensitivity to their concerns, perceptions, and attitudes.

Consistent with the overall goals of the Parent Infant Program, the initial assessment phase has three distinct focal points as depicted in the figure below.



Focal Points of the Initial Assessment

The interrelated purposes of assessment associated with the three focal points are:

1. *THE INFANT*

   To determine infant developmental competence and characteristics.

2. *THE PARENT-INFANT INTERACTION*

   To increase awareness of how the parent(s) and infant interact and how this interaction affects infant development and the parents' sense of competence.

3. *THE PARENT/FAMILY*

   To begin to identify and increase sensitivity to parental emotional and practical needs and how these impact upon their interactions with their infant and others.

WHAT IS INVOLVED IN ASSESSMENT OF THE INFANT?

Although initial assessment focuses on the parent(s) and their interactions with their infant, the primary focus of the Parent Infant Program initial assessment is the developmental assessment of the infant. Because of this, the infant's development is of primary concern for both parents and program staff, comprehensive assessment of the infant's skills takes a high priority.

PURPOSE OF INFANT ASSESSMENT

Infant assessment involves the systematic gathering of information concerning various aspects of the infant's behavioral and physical characteristics. Infant assessment can be performed for purposes of screening, diagnosis, program planning, and/or evaluation. In the Parent Infant Program, the primary reason for performing infant assessment is to provide input to the programming process. In response to the goals of the program, the aim of the PIP infant assessment is that the programmer, in cooperation with the parent(s), finds out:

- What the infant can do,
- What the infant can't do,
- How the infant does what he can, and
- How the infant tries to do what he can't.

Secondarily, periodic assessment provides a basis for program evaluation. That is, it provides information needed to evaluate program effectiveness at various intervals throughout the treatment program. This is done by comparing developmental skills of the infant at different points in the program (e.g., at the beginning and end of the program year) and determining developmental progress.

AREAS OF INFANT ASSESSMENT

In determining the needs of the infant, assessment is typically done within five major areas: gross motor, fine motor, cognitive development, language development, and social development.

1. *GROSS MOTOR*

   Gross motor development refers to an infant's spontaneous activity which enables him to move and changes him from a primarily horizontal to a vertical or upright being. It covers the transition from early reflex activity (i.e., automatic postures or movements over which the infant has little control) to more advanced voluntary functional posture and movement.

2. *FINE MOTOR*

   Whereas gross motor ability enables the infant to move about so that he can explore, it is an infant's fine motor skills which are involved in his actual manipulation of the environment. This area covers not only the refinement of the muscle control of the arms, hands, and fingers; but also deals with the development of the infant's sensory and perceptual skills such as vision.

3. *COGNITIVE DEVELOPMENT*

Cognitive development refers to an infant's thought processes which are involved in his "learning to learn", or in learning how he can control his environment or problem solve. Increasingly sophisticated cognitive skills enable the infant to apply abstract mental concepts to objects and to events that he sees happening in the environment.

4. *LANGUAGE DEVELOPMENT*

This area is probably more accurately referred to as the development of communication. It begins very early with touch and hearing (e.g., the parent holding the infant in a very secure way and talking very lovingly, the infant relaxed and calming in response and later may even smile and coo). The receptive language, or what the infant understands, comes before the expressive language, and actually provides the foundation for the infant to learn to verbalize his needs and wants to talk. The developing infant understands much more than he is able to express. This helps to explain why a gap of several months often exists between all of that talking and stimulation you give your infant and his later verbal response. All of the senses and the cognitive skills noted earlier are very closely involved.

5. *SOCIAL DEVELOPMENT*

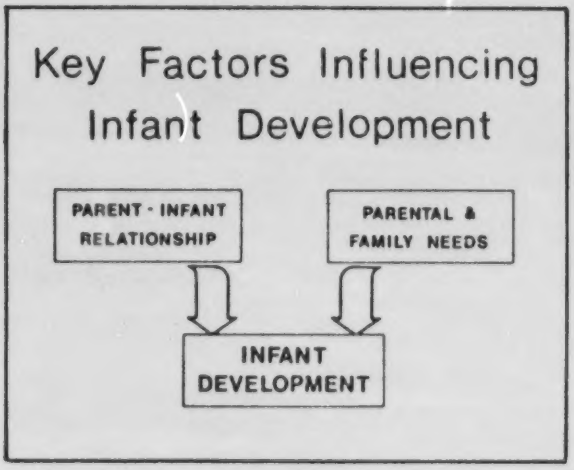
Probably the most basic of all five areas of development deals with the development of the infant's unique personality or temperament and the way he faces the world and his daily life situation.

In addition to assessing the development of specific infant behaviors (i.e., gross motor, fine motor, etc), the Parent Infant Program is also concerned with assessing those basic characteristics which reflect the overall nature of the infant such as: motivation, attention span, pleasure in success, persistence, distractibility, tolerance of stimulation, etc.

It is important to keep in mind that all areas of development are closely interrelated and that, in order to really understand the infant, all areas must be viewed as a whole. The division of these areas is to facilitate explanation and definition of development only. In reality, they cannot be divided. Each action of the infant involves some aspect of each developmental area. It is also important to remember that development occurs at different rates in different areas, and is not always forward. A growth spurt in one area may be accompanied by a temporary leveling off or regression in another area.

FACTORS INFLUENCING INFANT DEVELOPMENT

The infant is a starting point for and a primary focus of the initial assessment. Determining the infant's level and nature of functioning is necessary for planning a program that is responsive to his needs. It is because the infant's development is of primary concern that all factors which have a major influence on this development must also be addressed. During infancy, the parents, to a large extent, mediate or translate the environment for the infant. Their behavior, abilities, attitudes, and particularly, their interactions with their infant have a lasting impact on his development. Therefore, during the initial assessment, as well as throughout the programming process, program staff must increase sensitivities to these influencing factors, particularly those relating to the parent-infant interaction and to parental/family attitudes and emotional status. The figure which follows helps to illustrate the relationship of these factors.



Thus, although the infant's development may be the ultimate target for change, it cannot be isolated from the environment which supports and nourishes it.

WHAT IS INVOLVED IN ASSESSMENT OF THE PARENT-INFANT INTERACTION ?

The parent-infant relationship and interaction is also an important focus of observations made during the initial assessment phase. Since the programmer works indirectly with the infant "through" the parent, the way the parent interacts with his/her infant takes on a considerable importance to the programmer(s). It impacts the nature of the input and intervention that is planned for the family and how this input will be provided by programmers.

The assessment of how a parent interacts with the infant is usually informal, unstructured, and subtle. That is, during the initial interaction with families and during initial observations of both the infant and the parent(s) working and playing together, programmers should try to form an initial "feeling" of how the parent perceives and interacts with his/her infant.

In this process, programmers should begin to ask themselves the following questions:

- How does the parent interact with the infant?
- How does the parent perceive the infant and his/her developmental capabilities?
- How does the parent's behavior affect the infant's behavior?
- How does the infant's behavior affect the behavior and attitudes of the parent?

Several opportunities exist during the initial assessment phase for observations of parent-infant interactions and for gaining a perspective on how parents perceive their infant and his/her development. During the initial home visit, the developmental observations and, finally, during the more formal developmental assessment, programmers should not restrict their observations to the infant alone. Rather, an effort should be made to sensitize oneself to how the parents interact with the infant, how they implement what is suggested, the types of attitudes toward the infant that is communicated, etc. Such a sensitivity is critical to a continuing productive relationship with the parents and to the optimal program impact on the infant.

Although these observations begin during the initial assessment phase, they certainly do <u>not</u> end there. In fact, it is a rare case in which a program manager can get an accurate feel for the parent-infant relationship in the first few contacts alone. The type of parent-infant interactions may well fluctuate from one contact to the next and may be influenced by the time of day, the setting, the mood of the parent and/or the mood of the infant. Therefore, it is only after numerous contacts with the family and opportunities to observe interactions that the program manager can begin to assess interactional patterns. It is a process which continues throughout the program, and therefore, the topic recurs frequently throughout this manual.

WHAT IS THE PURPOSE OF THE ASSESSMENT OF PARENT OR FAMILY NEEDS ?

Another purpose of the initial assessment phase is to determine, at the outset of the program, what specific needs the parents or family have that can be addressed by the Parent Infant Program.

The following questions are addressed during the initial assessment that will assist in determining parental/family needs:

- What are the parents' existing skills and knowledge concerning their infant's development and handling?
- What are the parental expectations of the program?

- What are the expressed needs for information and ongoing assistance?

Again, there are several opportunities during the initial assessment process which allow the program staff working with the parent(s) and infant to determine their initial needs. This is a cooperative process where program staff assist parents in articulating their concerns and needs for information and assistance, and then provide suggested options for meeting these needs throughout their involvement in the Parent Infant Program.

Thus, these questions continue to be of key interest to the program manager throughout his/her involvement with the family. As rapport is established, the program manager becomes better able to determine needs of the parents that may not have been expressed or observed during the initial assessment phase.

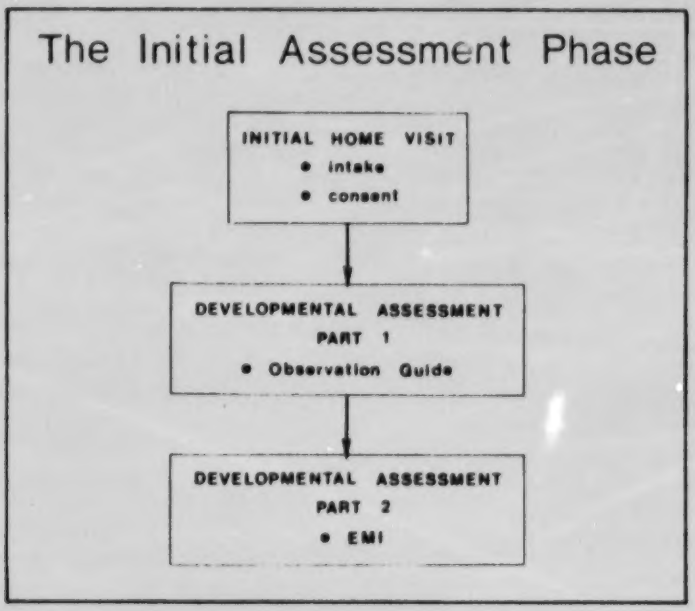
CONCLUDING COMMENTS

Throughout the initial assessment phase, the program staff and parents work together closely in accomplishing program goals. And, although during this phase much valuable information is obtained by the programmers, the phase is not limited to obtaining data from parents. It is also the first opportunity for program staff to provide parents with needed information and to actively involve them in the work with their infants.

Now that we have reviewed the purposes of the initial assessment phase, we can turn our attention to the process through which these purposes can be accomplished.

THE INITIAL ASSESSMENT PROCESS

Initial assessment is the first phase of the Parent Infant Program process. As depicted below, this phase involves three basic steps: initial home visit, developmental assessment part 1, and developmental assessment part 2.



The key questions addressed in this section are:

- What is accomplished in the initial home visit?
- What is the PIP developmental assessment?
- What should be done prior to the actual assessment?
- What is the Developmental Observation Guide and how is it administered?
- What is the EMI and how is it administered?

WHAT IS ACCOMPLISHED IN THE INITIAL HOME VISIT ?

The initial home visit is often the first face-to-face contact with the parent(s). Depending on the extent and nature of previous contacts with the family, the initial home visit provides the opportunity to accomplish several purposes:

- Establish a working relationship and rapport,
- Provide parents with information on the PIP,
- Determine parental expectations of the program,
- Ascertain the emotional status of the parents,
- Observe the infant and parent-infant interactions, and
- Obtain consent and agreement.

ESTABLISHING A WORKING RELATIONSHIP AND RAPPORT

Developing a good rapport and working relationship with the family is a process which will continue throughout the program manager's contact with the family. One of the advantages of the initial home visit is that the program manager is able to talk with the parent(s) on their own turf - in the comfort of their own home. The initial home visit provides a first opportunity to communicate to the parent(s) that they are important, their concerns are valid, and their input is valued by the program.

PROVIDING PARENTS WITH INFORMATION ON THE PIP

Although in most cases parents will have already received descriptive information on the Parent Infant Program in earlier contacts with the program staff, it is important to take time to carefully describe the PIP model and its goals. It is particularly important to be as specific as possible about what the program can and cannot do for the family. This will hopefully dispel any unrealistic expectations that are held by the parents and minimize risks for later dissatisfaction on the part of the parent.

It is equally important to assist parents in understanding "their" role in the program and the expectations that the program will have of them. Likewise, communicating your role and responsibility as a program manager is important.

DETERMINING PARENTAL EXPECTATIONS OF THE PROGRAM

During the initial contact with the family it is important to determine "their" expectations of the program and the program staff. What do they as parents hope to accomplish through participation in the program? What do they expect their child to accomplish as a result of participation in the program? What are their perceptions of "their" role and responsibility in the program?

What do they feel is the responsibility of the program?

It is necessary to discuss these expectations with the parents. During these discussions, the program staff should:

- Clarify roles (if necessary),
- Help dispel unrealistic expectations,
- Restate the intent and goals of the PIP,
- Specify (to the extent possible) what the program "can" and "cannot" do.

ASCERTAINING THE EMOTIONAL STATUS OF THE PARENTS

During informal conversations with the parents, it is often possible to begin to approach how they are feeling, what emotions each parent has, and how they are coping with the probability that their infant has a developmental disability. In order to work effectively with the family, it is important to understand where they are on the continuim of adjustment and what their concerns are at the present time. Stages in adjustment are seldom, if ever, clearly defined and are often intermixed. Responses fluctuate and often previous adjustment is recapitulated during a new phase of the infant's development or when the parent's hopes and expectations are not realized. Both parents are individuals and often they are at different stages of adjustment.

Whatever the parent's feelings and beliefs are at the time, it is important to realize that they are appropriate for the circumstances. The program manager can foster rapport and a trusting relationship by listening to the parents with an attitude of acceptance and openness and can help by reflecting their expressions back to them.

OBSERVING THE INFANT AND PARENT-INFANT INTERACTIONS

The initial home visit often provides an opportunity to observe the infant for the first time. The program manager, in talking informally with the parent and playing with the infant, can determine the following:

- How does the infant function/behave in his/her home environment?
- What is the infant's overall temperament?
- How does the parent(s) interact with the infant?
- What role do siblings (if any) play in the infant's play or care?
- How does the parent(s) perceive the infant (i.e., what strengths, what weaknesses?)
- What is the parent's understanding of the infant's developmental problem?

In talking with the parents during the initial home visit, the program manager can obtain valuable information about the infant which will bear upon later assessment and programming planned for him/her.

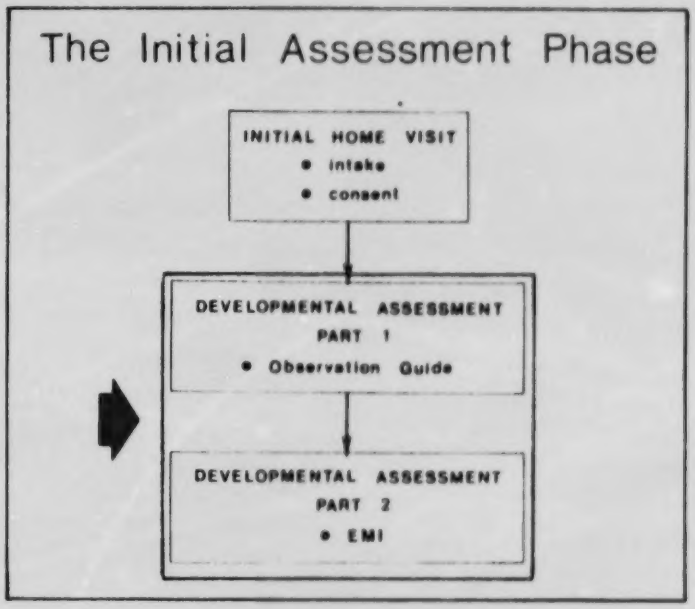
OBTAINING CONSENT AND AGREEMENT

The initial home visit may be the first opportunity to have parents sign any agreements or consents that the program needs for release of information from outside agencies/physicians, media releases, etc. Prior to asking parents to sign any kind of consent, a thorough description should be provided of the range and limitations of their consent. Ample time should be allowed for questions and discussions.

WHAT IS THE PIP DEVELOPMENT ASSESSMENT?

As depicted below, the PIP developmental assessment is basically a two step process involving:

- PART I - developmental observation of the infant and his/her interaction with the environment using the PIP Observation Guide, and
- PART II - determination of specific developmental skills of the infant using the norm-referenced scale, the EMI (Education for Multihandicapped Infants).



WHAT SHOULD BE DONE PRIOR TO THE ACTUAL ASSESSMENT ?

After the initial home visit, a developmental assessment is planned for each infant. Since the initial developmental assessment is so critical to the quality of the program manager's subsequent programming and work with the family, it is important that the steps in the assessment be well planned and understood by all staff involved. Prior to the actual assessment, each program manager should:

- Become familiar with his/her infant and family,
- Understand the assessment tools and procedures,
- Understand the intent behind the specific assessment items, and
- Have appropriate special positioning equipment or adaptive materials available.

BE FAMILIAR WITH YOUR INFANT AND FAMILY

Prior to meeting any family of a developmentally delayed or disabled infant for the purpose of assessment, it is best to know the infant "on paper" as well as possible. As a professional, you must still keep an open mind and interpret your actual observations objectively. However, you can be sure the parents have answered every question you ask at least twice before. Being considerate in this way will help ease anxiety and tension on the part of the parents and help you initiate rapport.

KNOW YOUR ASSESSMENT TOOLS AND PROCEDURES

Study the two assessment tools with which you will be working. Try to become as familiar as possible with the procedures and the actual assessment tools. For Part I of the assessment, become familiar with the procedures involved in the initial development observation and the questions asked on the Observation Guide. Reherse in your mind how you will set up the room, what toys will be available, what you will say to the infant's parent(s), how you will involve them, etc.

For both Parts I and II, know the EMI. Study the specific behaviors and their sequence in each area of development. Try to determine in your mind the skills that are appropriate for the chronological age and history of the infant with which you will be working. Keep in mind the behaviors that you will be looking for during the developmental observation with the parents. Learning as much about the infant as you can prior to the initial observation will assist you in developing an organizational framework for what you will be observing and will make you feel more comfortable and confident.

UNDERSTAND THE INTENT BEHIND THE SPECIFIC ASSESSMENT ITEMS

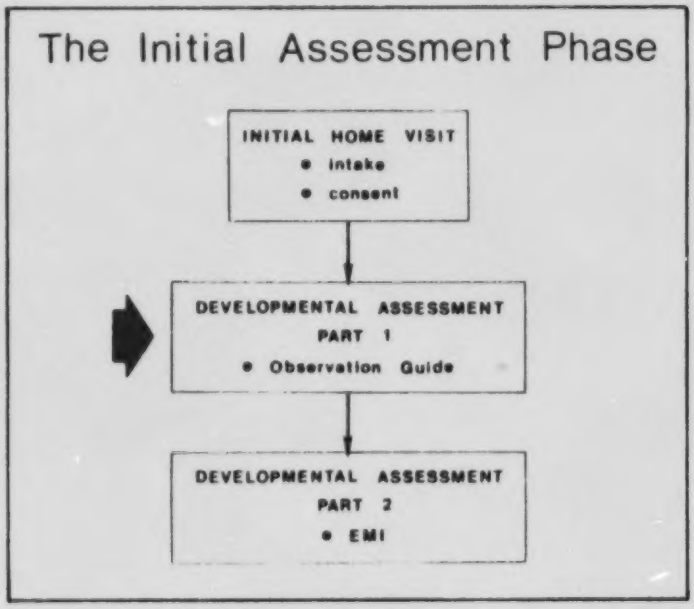
On the EMI, each behavior listed represents a certain concept or developmental skill. The behavior itself is not sacred. If the intent of the item is demonstrated, note such and qualify. For example, an infant who searches for mommie hiding behind a chair has at least the beginnings of "object permanence",- even if he won't or can't uncover a "Cheerio".

HAVE SPECIAL MATERIALS OR EQUIPMENT READY

In some cases, special positioning equipment or adaptive materials are required. This, of course, includes developmentally appropriate toys and stimulation materials. Again, reviewing the infant's file beforehand, greatly facilitates this step.

WHAT IS THE DEVELOPMENTAL OBSERVATION GUIDE AND HOW IS IT ADMINISTERED ?

The Developmental Observation Guide is the primary tool used in part I of the developmental assessment.



In this section, part 1 of the developmental assessment is reviewed in terms of:

- Purposes,
- Administrative guidelines,
- Types of observations made,
- Parental involvement, and
- Videotaping observations.

PURPOSES OF THE INITIAL OBSERVATIONS

As the first part of the initial assessment, the Initial Observation has several purposes associated with infant assessment, parent-infant interaction, and parent involvement.

1. *INFANT ASSESSMENT*

   It provides an opportunity for parents and programmers to observe "what" the infant can and cannot do to assist and "how" he does what he is able to do, in a loosely structured situation. This is valuable information for both programmers and parents in determining the infant's strengths and his areas of need, and in assessing how the infant responds to his environment. In this way, it is a prelude to the assessment of the infant using the norm-referenced EMI.

2. *PARENT-INFANT INTERACTION*

   The developmental observation provides an early opportunity to begin to assess parent-infant interactions. By allowing the parent(s) to engage in free play with the infant, the programmers can begin to determine how the parent interacts with the infant and how the infant responds to the parent. These observations, along with those made throughout working with the family, will assist programmers in developing programs that fit the parent-infant style of interaction.

3. *PARENT INVOLVEMENT*

   The developmental observation should be as much a exercise in observation for the parent(s) as it is for the program manager. It provides an initial opportunity to actively engage parents in observing their infant's behavior and to work with the program staff. As one of the first activities of the program that focuses on the parent(s)' primary concern, the infant, it provides the opportunity for parents to become aware of the value placed on their input and involvement in the Parent Infant Program.

ADMINISTRATIVE GUIDELINES

The Observation Guide is the procedural framework and recording form for making the initial observations. It is used by the program manager and other program staff to guide observations.

It takes approximately 30 minutes to complete the initial observations. The observations of infant and parent-infant behavior are all made within three situations which are set up by the program staff. These are:

1. *INFANT FREE PLAY (5-10 mins.)*

   Observations of the infant's interaction with and exploration of objects without interference or prompts from others.

2. *PARENT-INFANT FREE PLAY (5-10 mins.)*

   Observation of parent's handling/positioning and the infant's responses in structured play with parent(s).

3. *PROFESSIONAL AND PARENT-INFANT FREE PLAY (5-10 mins.)*

   Observation of infant's behavior when adaptations to position, stimuli, method of presentation or timing are made by staff and/or parent.

Arrangements should be made with parents to do the initial observations at a time when the infant is at his/her "best". Both mother and father should be asked to be involved. Prior to making observations, the parent(s) and infant should be comfortably and yet strategically situated in the room. The infant is usually placed on the floor with several toys that he reportedly likes around him. The overall procedure for observations should be communicated to the parents and they should be encouraged to comment and participate freely. If the infant is comforted by the proximity of the parent(s), then, they should sit on the floor near the infant as though to play with him or her. Otherwise, the program staff and parent(s) may sit together on the floor around the infant so that his/her free play can be observed unobtrusively.

TYPES OF OBSERVATIONS MADE

Four basic types of observations are made during the developmental observation: those associated with infant free play, those associated with parent-infant free play, those associated with professional and parent-infant free play, and general behavioral characteristics which crosscut all areas of free play.

1. *INFANT FREE PLAY OBSERVATIONS*

During the first 5 to 10 minutes, the infant is left to play alone and observations are focused on the infant's behavior/performance when left to his/her own devices. The observers should limit interaction with the infant to a minimum, allowing the infant to explore alone. During the time for free play, the infant should be placed in several positions that are functional for his/her age. For example, for a young infant, unable to sit, time should be given to observations of play both in prone and supine positions. If able to sit, then time for play in sitting should be taken.

During the free play of Part I, the following specific observations should be made:

- *What is the infant's initial reaction when placed on the floor and left to play alone (e.g., level of distress, interest, etc.)?*
- *What is the nature of the infant's motor activity (e.g., attempts to locomote, orient towards objects or people, random movement, etc.)?*
- *Describe the infant's general awareness, interest, and responsiveness to his/her environment (e.g., toys, people, room, etc.).*
- *How does the infant explore toys/events around him and his own body? Describe the infant's manipulation of objects; visual auditory and motoric orientation to objects; preferences; verbalizations; etc.*
- *How does the infant communicate interests, desires, preferences, etc?*

2. *PARENT-INFANT FREE PLAY OBSERVATIONS*

The second period of observation (5-10 mins.) focuses on the infant's behavior as he/she plays with his/her parent(s). It also provides an opportunity to observe how the parent interacts with the infant and visa versa. If both parents are present, an attempt should be made to involve them both in free play with the infant. Ideally, observations of mother-infant free play, father-infant free play, and both mother and father in free play with the infant should be made. This is not always possible without creating a "stilted" play atmosphere. Therefore, parents should be asked to play with their infant as they do at home, suggesting that each parent do something with the infant that they and/or the infant particularly like doing together.

During the 5 to 10 minute period of play, the observers should be seated near the parents on the floor to put the parents more at ease. The following observations should be made:

- *What type of play is initiated by the parent(s)? (Specify toys used, verbal and physical prompts given, sequence of play, and timing.)*
- *How does the infant explore and interact with objects? How does the infant respond to the parents' behavior?*
- *How does the infant respond to the parents' positioning and handling? Describe parents' handling of the infant.*

3. *PROFESSIONAL AND PARENT-INFANT FREE PLAY OBSERVATIONS*

Once the infant has had ample time to play alone, and parents have had the opportunity to play with the infant, the program staff takes time to handle and play with the infant. The purpose of this part of the observation is to provide opportunities for the infant to play which were not provided in preceding free play experiences. Modifications in positioning, handling and/or elicitation of specific behaviors that were not previously observed are attempted here. Observations should center on the following:

- *How does change in positioning/handling effect the quality of the infant's responses (motoric, visual, and/or affective responses)? Specify position and adaptations made and the infant's response to each.*

- *Note any variation in stimulus materials presented, method of presentation, or timing from that observed in the parent-infant free play and describe the infant's response to each.*

4. *DESCRIPTION OF GENERAL BEHAVIORAL CHARACTERISTICS*

During observations in parts 1, 2, and 3; the program manager should assess the infant's overall temperamental and psycho-social characteristics. Infant behavior should be described within the following areas:

- *Social Orientation - responsiveness to caretaker and to other persons;*
- *Fearfulness - reaction to the new or strange (e.g., to strangers, strange situations, play materials, etc.);*
- *Tolerance - tolerance of the infant for demands of the situation or of stimulation;*
- *Object Orientation - responsiveness to objects, toys, or test materials;*
- *Consolability - the manner and degree of consolability when the infant has become upset;*
- *Activity - the amount of voluntary gross bodily movement;*
- *Reactivity - the ease with which the infant is stimulated to react in general (i.e., his sensitivity or excitability which may be positive or negative);*
- *Response to Frustration - the manner and degree of the infant's response to frustration;*
- *Attention Span/Persistence - tendency to persist in attending to any one object, person, or activity aside from attaining a goal; and*
- *Muscle Tone - tone or tension of the body.*

At this point, the program manager should try to determine what type of infant this is and the kinds of contributions that he/she makes to the parent-infant relationship.

PART I:

Response To Environment - Free Play

(5 - 10 mins.)

Place the infant on the floor with several toys appropriate to his/her level of interest. The parent(s) may sit near the infant for comfort, if necessary, but should remain minimally involved in his/her play. Make the following observations in several positions (i.e., prone, supine, etc.,- note position in describing observations).

1. What is the infant's initial reaction when placed on the floor and left to play alone (e.g., level of distress, interest, etc.).

   SUPINE - visualized red ring and jingle bells suspended on dowel-rod overhead although kept turining head to locate parents - began whimpering when parents moved out of easy sight - when mother returned to Mary's side, she quieted again although she seemed more interested in her mother than the toys

2. What is the nature of the infant's motor activity (e.g., attempts to locomote; orient towards objects or people; random movements)?

   SUPINE - when attempting to raise head, total trunk and legs also raise - arms frequently move together with increased activity of upper extremities although did demonstrate purposeful swatting at suspended objects - both hands fisted most of the time - asymmetrical tonic neck reflex present in both sides, however, Mary can move out of total pattern

3. Describe infant's general awareness, interest, and responsiveness to his/her environment (e.g., toys, people, room).

   General alertness to surroundings was evidenced by her visual direction to people and objects - she also oriented to voices in the room attempting to look in the direction of a voice - she displayed most interest and responsiveness to her parents

4. How does the infant explore toys/events around him and his own body? (Describe infant's manipulation of objects; visual, auditory, and motoric orientation to objects; preferences; verbalizations.)

   Mary visually explores objects and is able to track a moving object throughout her field of vision (horizontally and vertically) - she attempts to reach for objects, usually with hands fisted, and can make physical contact with objects - is able to grasp rattle in hand in sitting position, but does not demonstrate active release

5. How does infant communicate interests, desires, preferences, etc.?

   Vocalizes in response to parents' verbalizations - appropriately smiles in response to social contact - seems to distinguish between parents and strangers - whimpers when in discomfort (i.e., seated in kiddie carrier in prone position) - maintains eye contact with objects and people

PART II:

Parent - Infant Free Play

(5 - 10 mins.)

Make available to the parent(s) a number of toys and materials of varying developmental levels and stimulation characteristics (e.g., loud, quiet, bright, soft, etc.). Encourage the parent(s) to choose materials which they feel will appeal to the infant and to play with the infant as they would at home.

1. What type of play is initiated by the parent(s)? (Specify toys used, verbal and physical prompts given, sequence of play, and timing.)

   ON BACK: Play with toy was attempted - a toy with moving parts was presented by father and moved throughout visual field - father seemed sensitive to Michele's interest level and moved object slowly enough for her to follow - ceased activity when she appeared to lose interest. Mother spent a great deal of time in social/physical interactions which Michele seemed to really enjoy - involved Michele in total interaction by allowing sufficient time for her to respond - Laughter was noted as one response. Both parents seemed a little over-concerned in eliciting from Michele an "appropriate" response such as laughter, open hands, etc. - they insisted that Michele is typically more active and responsive when in the home environment.

2. How does the infant explore and interact with objects? How does the infant respond to the parents' behavior?

   Michele, as previously stated, visualizes objects and reaches/swats at them especially with right hand - she was most responsive, however, to attention given by parents and actively sought their attention and response during their interaction.

3. Describe the parents' handling of the infant.

   Mother allowed ample time when telling/asking Michele to assist in pulling to sit - Michele demonstrated good head position/control (maintained head in stable position with trunk) when pulled to sit - Increased extensor tone was noted on several occasions when the father lifted her by arms to an upright position - more rough-house play noted with father (e.g., swinging up in air, turning her upside down) although she did not appear distressed.

PART III:

Professional and Parent - Infant Play

(5 - 10 mins.)

In play with the infant, make modifications in handling and stimulation based on observations of infant play during Parts I and II. Report all adaptations attempted and indicate the infant's response to each.

1. How does change in position/handling affect the quality of the infant's responses (motoric, visual, and/or affective responses)? Specify position and adaptations made and the infant's response to each.

   -- *Prone position appears to be the worst position for head and arm control - she seems to tire readily when attempting to actively lift her head and extend her trunk.*

   -- *Supine position seems to be slightly better position for movement of arms although neck flexion causes total body flexion - hands seem fisted most of the time - legs in the total extension with scissoring appearance.*

   -- *Sitting with hips, knees, and trunk in slight flexion seems most conducive to total body control - upper trunk must be supported - she seems able to maintain longer head control than in other positions and both hands are free to explore objects at midline - hands appear to be more easily opened.*

   -- *In GM love seat - appears too confined - does not provide freedom of movement of arms although tone in upper and lower extremities seems more normalized - arches back and pushes off of bottom of seat with legs to indicate that she wants out of seat - tolerates this positioning for only 5 minutes or so.*

2. Note any variation in stimulus materials presented, method of presentation, or timing from that observed in Part II and describe infant's response to each.

   Different types of toys (tiger toy, slinky) were presented which Michele visualized and attempted to hold - did not seem nearly as responsive socially to therapist as she had to parents - timing seemed right.

PART IV:

Description of General Behavioral Characteristics

(5 – 10 mins)

Describe the infant's behavior in the following areas.* Base your descriptions on your overall observations of and interactions with the parent(s) and the infant during Parts I - III.

1. Social Orientation - Responsiveness to caretaker and to other persons.

   Vocalizes, visualizes (maintains eye contact) and orients to voices of individuals - changes in motor activity were noted (either calming when upset or increasing when excited).

2. Fearfulness - Reaction to the new or strange (e.g., to strangers, strange situations, play materials, etc.).

   According to parents, Nichele was less active when introduced to novel people and toys, however, there were no overt signs of fearfulness, fretfulness were noted except when parents left her side.

3. Tolerance - Tolerance of infant for demands of situation or of stimulation.

   Tolerance to this entire period of "play"-interaction was good - she was able to tolerate all demands if one or both parents were within close proximity - only towards end of session did she become more fretful since she seemed to tire at this point.

4. Object Orientation - Responsiveness to objects, toys, or test materials.

   Nichele actively visualizes objects and follows them throughout visual field - she attempts to reach for objects in swatting motion especially with right hand and orients to voices by turning head in direction of sound.

5. Consolability - The manner and degree of consolability when the infant has become upset.

   Parents did not appear to have any difficulty in consoling when Nichele became upset - physically holding and comforting her caused a decrease in crying. She seems able to console self to some degree by seeking out parents' attention.

*Taken from the Carolina Record of Infant Behavior, Experimental Form.

PART IV CONTINUED

6. Activity - Amount of gross bodily movement.

Arms are able to move symmetrically and also singularly when swatting at objects with one hand (some overflow into other side) - legs move symmetrically most of the time although some disociation was seen. Generally, legs are maintained in scissored posture.

7. Reactivity - The ease with which the infant is stimulated to react in general; his/her sensitivity or excitability (may be positive or negative).

Social types of contact seem to arouse the most reactivity - Michele reacted positively by visualizing and swatting at objects held and moved by another person - some reactivity was noted during free play (visualization and arm movement) although not to as great a degree.

8. Response to Frustration - The manner and degree of the infant's response to frustration.

Frustration was observed most when confined to sit - total body movement to free self from chair with combined whimpering - such behavior was persistent until taken out of seat.

9. Attention Span/Persistence - Tendency to persist in attending to any one object, person, or activity aside from attaining a goal.

Michele demonstrated good visual attending behavior to parents during interaction and to preferred toys - she persisted in arm movements directed towards objects within easy sight and reach.

10. Muscle Tone - Tone or tension of the body.

Increased extensor tone especially in legs was seen when lying on back and when lifted straight up in the air - increased tone throughout entire body was noted when lifting head when on back - asymmetrical tonic neck reflex was apparent to either side.

INVOLVING THE PARENTS

The initial observations set up one of the first learning situations for parents as well as for the program staff working with parents by:

- Allowing the professionals to gain a better understanding of the parents' perceptions of their infant's behavior and personality; and
- Affording the opportunity to reinforce or sharpen parental observation skills and to assist the parent(s) in interpreting their infant's behavior.

With these two ends in mind, review the following general guidelines for interacting with the parent(s) during the initial observation.

Gaining a Perspective on the Parent's Perceptions:

Viewing the infant with the parents presents an excellent opportunity to tune in to how the parents observe and interpret his/her behavior. It is important to understand that there will be occasions when perceptions of the parent are different than those based on the same observations made by you,- the professional. Remember,- perceptions, although based on objective data, are "subjective" and flavored by many factors including the individual's history, expectations, emotions, and the immediate context. For example, one observer may perceive an infant as showing admirable persistence in attaining his/her goal, while another observer watching the same behavior, may see a helpless infant unable to accomplish even the simplest of tasks. We can learn a considerable amount about how parents perceive their infant by allowing them to describe their observations. This information is helpful later when working with the parents on a weekly basis.

During the initial observation, the professional's role is one where parents are supported in their observations even though the infant's behavior may be perceived differently by the professional. It is the professional's responsibility to encourage parents to collaborate with them in making observations and to reinforce their constructive input.

Parents can be assisted in commenting on what they are observing by asking leading questions such as:

- *What do you think Matthew is attempting to do here?*
- *Why do you suppose he* _____ *?*
- *How does he do (specify activity) at home?*

Sharpening Parental Observations:

The time spent with parents during the initial observation can also be used to help increase the parents' sensitivity as observers of their infant's behavior. This can be accomplished in the following ways.

1. *COMMUNICATE THE "VALUE" OF OBSERVATION*

Parents should be guided in understanding how accurate observations can assist in making important decisions regarding their infant's developmental needs for programming. The purpose of the initial observation, as well as the nature of the Observation Guide, should be explained.

2. *HELP PARENTS MAKE THEIR OWN DECISIONS*

Assist parents in making decisions about their observations. Provide help as needed in interpreting "their" observations.

3. *FOSTER SENSITIVITY AND SHARPEN AWARENESS*

Make parents aware of the different schema that the infant demonstrates throughout the initial observation. Point out the different actions that the infant has in his/her repetoire. Finally, point out the infant's initiatives, underscoring the importance of the infant's exploration of his environment, his/her interests, preferences, and persistence. Try to emphasize the competencies that the infant demonstrates rather than his/her deficits. Keep in mind that parents will model the professional's behavior,- so verbalize your observations as you make them.

4. *SUGGEST FOLLOW-UP OBSERVATIONS*

As a follow-up activity, you might suggest that the parents carry similar observations over to the home during the week. Have them make note of such things as:

- *How the infant explores toys,*
- *Preferences shown,*
- *Time spent attending to different play activities, and*
- *Ways the infant communicates to others around him/her.*

VIDEOTAPING OBSERVATIONS

Where videotape equipment is available, it is definitely advantageous to use it during the initial observations because it:

- Permits the opportunity for reviewing the infant's behavior and play with the parent(s);
- Provides a permanent record of the infant and of the parent and infant in free play which can be used by program managers and other staff working with the infant for future reference; and

- Provides a record of entry-level skills of the infant which can be referred to at a later date by parents and staff to assess progress.

In using videotape in the initial observation, the following procedures are suggested:

1. Have videotape equipment set up in the room prior to the parents' arrival. The camera and/or the infant should be situated such that it is possible to get a good angle of the infant lying on his/her stomach, on his/her back, and in any other position(s) appropriate for play. Make certain that the view of the infant's eyes, head, arms, and feet are unobstructed. It is wise to set up with a doll prior to taping the infant to assure the proper position of camera and infant. The important thing to remember is to know "what" you are looking for and getting the best possible picture of it. It is advantageous to have a person familiar with the Observation Guide and its intent to operate the camera.

2. Explain to parents prior to the initial observation that videotape will be used. When parents arrive, try to make them comfortable in the presence of the camera. Try to focus as little attention as possible on the camera. If you ignore the camera and redirect attention to the infant, parents will follow suit. Every effort should be made to make the camera equipment as unobtrusive as possible.

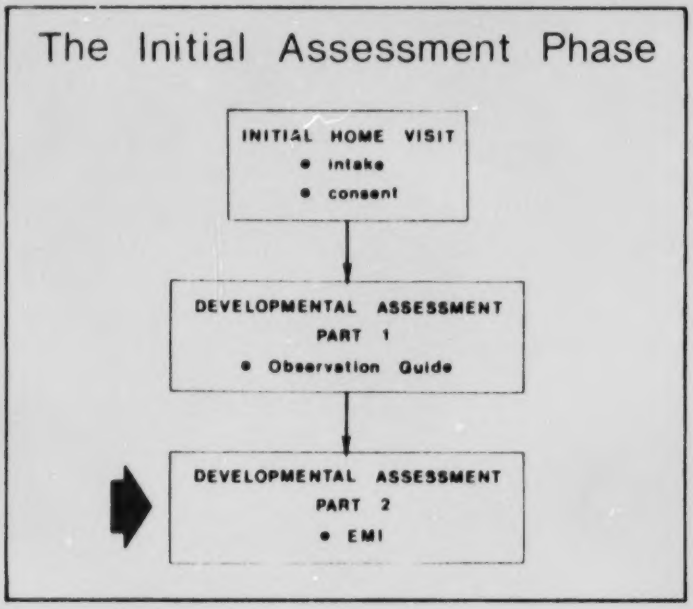
3. Spend some time with the parents talking and playing with the infant after getting things set up and before the actual taping.

4. Tape Parts I, II, and III of the Observation Guide. Taping should be stopped between each section.

5. Play the tape back for the parents. The program manager should comment on the infant's behavior and interpret his/her observations. Encourage parents to make comments on the infant's behavior too. Ask questions of parents and stimulate their questions and interpretations.

WHAT IS THE EMI
AND HOW IS IT ADMINISTERED ?

Having made the initial home visit, and having observed the infant and parent(s) in the developmental observation; the program manager should have acquired a fairly good "feel" for the infant and for how he/she interacts with his/her environment (including parents). As depicted in the diagram below, Part II, the administration of the EMI, completes the initial assessment phase and should result in a comprehensive and complete picture of the infant.



A large percentage of the EMI can be completed by the program manager from observations made and noted on the Observation Guide. However, during the administration of the EMI, many other specific behaviors not previously assessed and those that were observed earlier may be verified. Whereas the initial observations were made at a time scheduled outside that of the Developmental Classes, the EMI may be completed during the initial weeks of the classes in the regular class period.

In this section we will review:

- How the EMI is used in the PIP,
- The EMI recording form, and
- The EMI administration manual.

HOW THE EMI IS USED IN THE PIP

The EMI is a norm-referenced infant developmental assessment. It depicts the major developmental skills accomplished by the "average" infant from birth to 24 months, looking at approximately 70 skills in each of the following five areas: gross motor, fine motor, cognitive, language, and social. The EMI was developed by The University of Virginia Medical Center.

In the Parent Infant Program, the EMI is administered by the family's program manager and a member of the PIP staff whose expertise complements the skills of the program manager. For example, if the program manager is a physical therapist, he/she might be assisted by a staff member who is a psychologist or a language specialist. This is usually scheduled during the regular class which occurs a week after the administration of the Observation Guide.

The EMI completes the total picture of the infant. It "fills" in the gaps" and provides a record of the infant's entry level performance on specific skills. The EMI is then repeated at the end of the school year or at the time of the infant's exit from the program in order to document progress and to provide an indication of program effectiveness.

THE EMI RECORDING FORM

The EMI Recording Form used by the Parent Infant Program is a modification of the original. The revised form was developed in order to allow the assessor to qualify observations made so as to clarify or pinpoint the infant's performance. This produces a more usable base of information on which to build later programming and to document future progress. Suggestions for most effectively recording assessment results on this form include the following. As you review these suggestion, refer to the sample page from the EMI provided on page 3-32.

1. Do not turn away from the infant to record observations during the active portion of the assessment. If you do, you will miss a great deal and tend to disturb the rhythm of the play. Record observations immediately after the assessment, or perhaps during breaks in the session when the infant is being fed, changed, or otherwise comforted by the parent.

2. Avoid the use of pass/fail terms. It is important to model to the parents an accepting attitude toward the infant. This can be facilitated by the use of non-judgemental terms such as "+" or "0" when indicating the presence or absence of a particular skill. A symbol such as "R" could be used to indicate a response not observed, but reported by parents as demonstrated at home. "N/A" might be used to indicate that an accurate assessment of the skill could not be made due to the infant's disability.

3. The aforementioned marks can be qualified in the "Response" space of the recording form. Here you should describe observations in specific behavioral terms, avoiding professional jargon. Appropriate remarks might include a reference to a specific stimulus that proved successful in eliciting a particular response, to a specific level of an emerging skill, or to special positioning or handling which preceded the observance of a particular performance.

THE EMI ADMINISTRATION MANUAL

The EMI Administration Manual, as modified by the Parent Infant Program, lists individual assessment items with a brief definition of each item to facilitate administration. Each item is then followed by the rationale behind the assessment of that particular behavior (i.e., an explanation of the underlying competency represented by the particular behavior).

Each developmental area is color-coded to match the EMI recording form to ease the location of a particular item's definition and rationale. Items are also cross-referenced across, as well as within, developmental areas in order to enhance the assessor's understanding of how specific skills relate, how one must build on another, or how the accomplishment of one skill facilitates the accomplishment of another.

Several items of the EMI represent behaviors which are clearly reflexive or otherwise unteachable (e.g., Gross Motor Item No. 1a, "Assymmetrical tonic neck reflex present.") For use in PIP programming, such items were omitted from the Administration Manual.

Sample Page From The EMI

GROSS MOTOR

Name Danny L.

No.	Developmental Levels / Items	Date	Response	Date	Response
		8/11/78		5/8	
	1 MONTH				
1a	Asymmetrical tonic neck reflex present	+		+	
1b	Lifts head when held at shoulder	+		+	
1c	Makes crawling movements, prone	+	rarely on left side; right side only	+	
	2 MONTHS				
2a	Turns from side to back	+	does not seem to be functional	+	
2b	Head held at body plane, ventral suspension	+		+	
2c	Lifts head consistently in prone	+	hi extensor tone on Left	+	some extensor tone on Lgt still present
	3 MONTHS				
3a	Head steady, forward, in sitting position	O	Not yet steady; bobbing with some control	+	tilts to Right on occasion
3b	Chest up, arm support, prone	+	better support on left side	+	
3c	Held standing, lifts foot, bears some weight	O	stands on toes, minimal weight bearing	+	bears some weight on toes

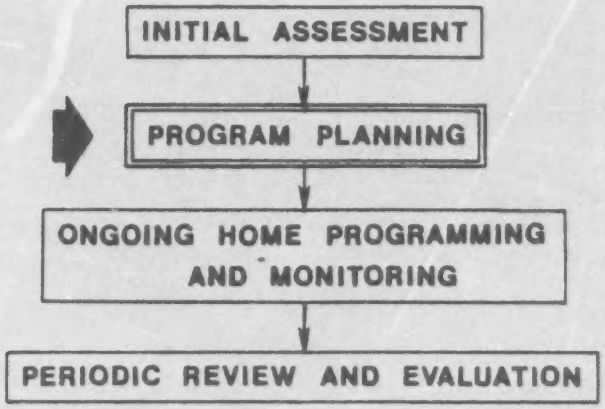
* Prone - lying on stomach
* Supine - lying on back

Score "+" if response meets criteria set in item definition.
Score "O" if skill not observed.
Score "R" for parent report.
Score "N/A" if accurate assessment of skill cannot be made due to infant's disability, explain.

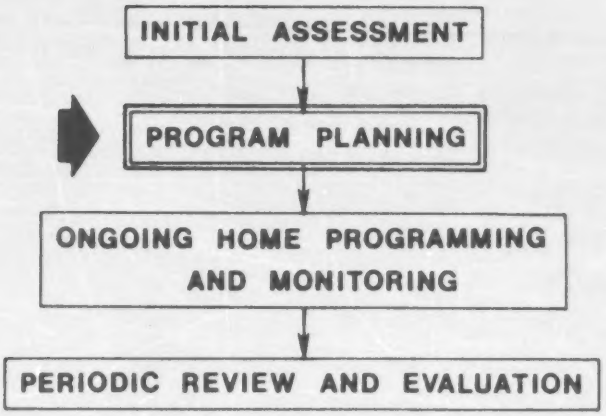
PARENT INFANT PROGRAM

SECTION

4



PROGRAM PLANNING



INTRODUCTION

The second phase in the Parent Infant Program process is program planning. This phase involves careful consideration of assessment information in planning for what will be accomplished during the family's participation in the Parent Infant Program. The process of translating assessment data into an effective program for working with infants and parents requires extensive analysis and planning on the part of program staff and parents.

THE PROGRAM PLANNING PROCESS

The key questions addressed in this section are:

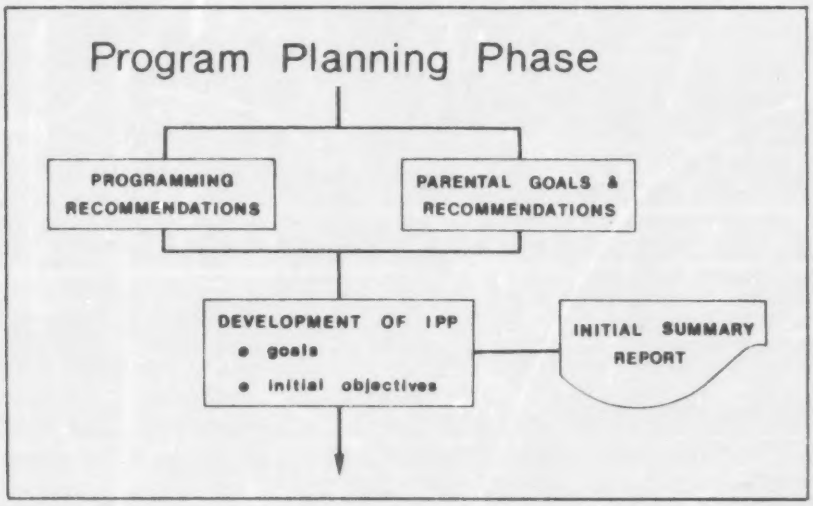
- What is the purpose of the program planning process?
- What steps are involved in the program planning process?

WHAT IS THE PURPOSE OF THE PROGRAM PLANNING PROCESS ?

The purpose of the program planning process is to develop a treatment program which is tailored to meet the unique needs of the infant and family. Information from the initial assessment phase constitutes the primary input to this process thereby ensuring the program's responsiveness to infant and family needs. The final outcome of the program planning process is the Individualized Program Plan (IPP) which provides the basis for subsequent work with the family.

WHAT STEPS ARE INVOLVED IN THE PROGRAM PLANNING PROCESS ?

The program planning phase involves four major steps as depicted in the graphic below.



The purpose of each of these steps is:

1. *PROGRAMMING RECOMMENDATIONS*

   To synthesize and integrate information obtained during the initial assessment from parent(s) and infant and writing recommendations for individualized programming.

2. *PARENTAL GOALS AND RECOMMENDATIONS*

   To obtain parental priorities and concerns for their infant's programming.

3. *DEVELOPMENT OF THE IPP*

   To develop an Individualized Program Plan for the infant which is based on recommendations of program manager, parents, and team.

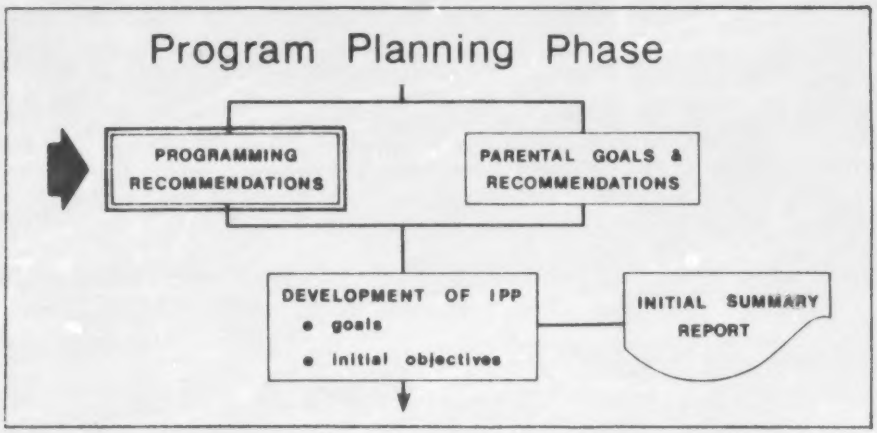
4. *INITIAL SUMMARY REPORT*

   To summarize initial assessment results and plans for programming in a report to parents, physicians, and other community agencies involved in the infant's development.

The rest of this section on program planning is organized around these four steps.

PROGRAMMING RECOMMENDATIONS
(Transition from Assessment to Program)

Programming recommendations constitute the first step of the program planning process.



The key questions addressed in this section are:

- What are programming recommendations?
- Who completes the programming recommendations?
- How is the programming recommendation document used?

WHAT ARE PROGRAMMING RECOMMENDATIONS ?

Programming recommendations are broad goals or recommendations for programming. They assist the program manager in making the transition from assessment results to specific goals and objectives for the infant. Programming Recommendations: A Working Document, is a tool developed to assist program managers in the task of synthesizing and summarizing information obtained during the initial assessment phase. It is a working document in that it is used by the program manager to facilitate the process of identifying targets for subsequent programming. It is also an aid to communication in that it provides a structure and basis for seeking input from and providing infomation to team members and to parents concerning the infant's strengths and weaknesses in each developmental area. Finally, it feeds into the subse-

quent program plan. That is, the information synthesized on the program recommendations document is refined and elaborated upon in the development of the Individualized Program Plan.

WHO COMPLETES THE PROGRAMMING RECOMMENDATIONS ?

The programming recommendations are completed by the program manager with the parents. During and following the assessment, program managers review results from each developmental area with the parent(s) and solicit input regarding their infant's functioning. In completing the programming recommendations, program managers and parents work within one area at a time, completing as much of the sections as possible for that area before moving on to the next. There is no particular order of completion. Remember, Programming Recommendations is a working document for the program manager and is the basis for the IPP.

HOW IS THE PROGRAMMING RECOMMENDATIONS DOCUMENT USED ?

OVERALL ORGANIZATION/FORMAT

The programming recommendations document consists of six parts. Parts I through IV are repeated in each area of development corresponding with the EMI: gross motor, fine motor, cognition, communication/language, and social. In each of these areas, Parts I through IV address:

- Specific skills observed in the infant,
- Target areas for programming,
- Special considerations related to programming and consultation, and
- Resource and service needs.

Parts V and VI are used for the notation of family-related goals and any additional considerations pertinent to programming.

RECOMMENDATIONS REGARDING DEVELOPMENTAL AREAS

As just noted, recommendations are made for each developmental area specified in the EMI. On the next page you will find sample recommendations made for the gross motor area.

Following is a brief explanation of how to complete each section of the programming recommendations document for the developmental areas.

Sample Page from the Programming Recommendations Document

Developmental Area: Gross Motor

I. Strengths and skills on which to build:

- *turning and rolling (side to back, stomach to back, back to side)*
- *emerging head control in prone position*
- *emerging ability to prop with arms when prone*
- *alternately kicking legs (on back and on tummy to attempt movement)*
- *mother reports crouching - arms out (i.e., almost to crawl)*

II. Target areas for present programming (goals):

- *improve head control (e.g., duration, in supported sitting position, in prone position)*
- *improve ability to sit (e.g., duration, tolerance, decreased support)*
- *locomotion - work on crawling*
- *controlled weight bearing from supported sitting*
- *functional body rotation - maintain and refine for play and movement*

III. Special considerations which might promote or hinder attainment of goals in this area:

Need to pay careful attention to positioning and handling to normalize muscle tone.

IV. Consultations, resources, and/or supplemental services needed:

- *physical therapy assistance from the team*
- *evaluate for adaptive seating such as a care chair and/or corner chair to promote better posture during play and mealtimes and for transportation needs*

☐ No needs at this time

1. *STRENGTHS AND SKILLS ON WHICH TO BUILD*

In this area, note specific strengths that you have observed in the infant. This is a particularly good area in which to solicit parental input since it underlines the infant's strong areas or existing competencies which a parent may tend to overlook in their concern for the infant's problems. Strengths can be derived directly from the infant's assessment. That is, some of the skills the infant did demonstrate become important for developing those he/she did not demonstrate. Be specific, yet concise. Complete sentences are not necessary.

2. *TARGET AREAS FOR PRESENT PROGRAMMING (GOALS)*

Indicate behaviors which all agree are appropriate targets for present programming. These should be based on:

- *Noted strengths,*
- *Observations of the infant during the assessment, and*
- *Family input and needs.*

This is more difficult than it first appears. There may be a number of skills that logically follow the skill observed in the infant during assessment. Determining which are the most important at this point in time takes considerable understanding of the infant and the severity of his/her disability in addition to a good understanding of the developmental sequence. Often the "next step" on an assessment, or in a given curriculum, is not the next step for the infant. To ensure "success" by the infant, a longer range target behavior must be broken down into finer steps. At any rate, the program manager should seek consultation in this area from other discipline members of his/her team.

At this point, parental input will most likely be in the form of their priorities for the infant. Any strong feelings by a parent to work on a particular skill should be noted. Some times parents will place high priority on a developmental area, such as gross motor, rather than on specific skills within one given area. These preferences should be noted and considered.

Once listed, the target areas should be prioritized. You may want to prioritize using the following system:

- *Primary Priority - should be emphasized in developing program, and*

- *Secondary Priority - important but not critical at this time.*

As an alternative, you may want to sequence them according to the order in which they should be developed throughout the programming process. These target areas, once finalized, serve as broad goals for the writing of more specific objectives and home activities.

3. *SPECIAL CONSIDERATIONS WHICH MIGHT PROMOTE OR HINDER THE ATTAINMENT OF GOALS IN THIS AREA*

Any special condition of the infant, the family, and/or the home which may impinge on the programming developed in this area should be noted here. Typically, these considerations relate to the infant's disability. For example, a notation for a blind infant in the cognitive area might read, "no vision - use other modalities in developing awareness of environment (e.g., auditory, tactile)". Considerations that have broader applicability to all programming in general should be noted in section VI.

4. *CONSULTATIONS, RESOURCES AND/OR SUPPLEMENTAL SERVICES NEEDED TO PROGRAM IN THIS AREA*

After completing sections I through III, the program manager should have a good idea of what he/she will need to be able to plan for the infant in this area. Assistance may be needed from a team member or outside consultant in identifying or prioritizing target behaviors. Or, the program manager may anticipate his/her need for assistance in developing activities to foster development in the target areas.

In addition, this section should include any supplemental services needed by the family or infant. These are services which will supplement the services provided by the Parent Infant Program via the Developmental Classes. The provision of these supplemental services should be based upon the infant's individual needs as determined by the parents and the staff. Following the initial assessment, needs for services should be noted with an indication of the urgency of the need (e.g., immediate, needed sometime during the program year, etc.).

Following is a listing of evaluative services that might be indicated following an initial assessment. Other needed services (not listed here) should also be noted in this section.

- *Optometry*

- *Language evaluation*
- *Audiology*
- *Dentistry*
- *Nutrition and feeding*
- *Physical therapy*
- *Occupational therapy*
- *Behavior management*
- *Physical medicine*
- *Neurology*
- *Nursing*
- *Psychology*
- *Social service*

Recommendations made in section III should be recorded in the infant's Individual Supplemental Service Record described on page 4- .

RECOMMENDATIONS REGARDING FAMILY-RELATED GOALS

Section V of the programming recommendations document deals with family-related goals. Not all of the goals established will be infant-related. There may be specific skills or areas of skills that a family member, or the entire family, may desire to accomplish. Such family-centered goals should be itemized in this section. Most often these goals will relate to a parent skill such as "handling".

ADDITIONAL INFORMATION/CONSIDERATIONS

Any information that relates to the infant's programming or parent/family input into this programming process which was not noted under sections I through V, should be mentioned here. These may include family circumstances that affect the overall programming of the infant.

PROCEDURAL CONSIDERATIONS

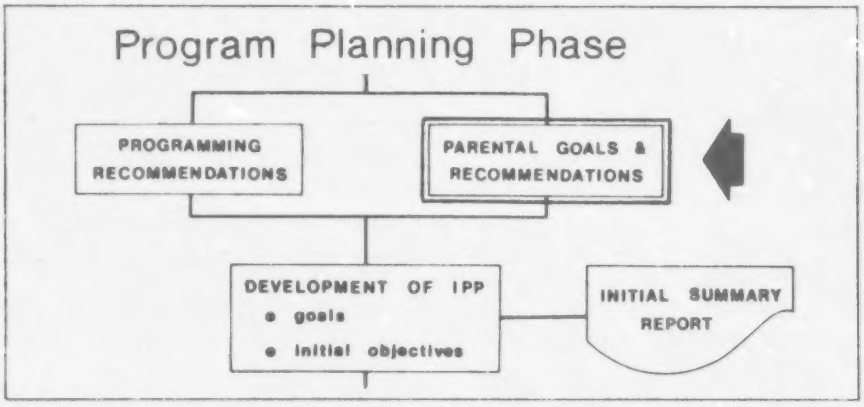
During and after completion of the programming recommendations, the program manager should consult with team members. This can be done in the regular team meetings prior to the Developmental Classes or during the third hour when parents are in the Parent Group. Program managers will want to seek assistance from other members in interpreting assessment results and identifying target areas for programming in areas outside their own discipline.

This will most likely require that program managers spend some time getting to know infants assigned to others on their team.

Upon completion of the programming recommendations, the program manager should update the status of the document on the face page, that is, the date on which the recommendations were reviewed and approved by the team.

SOLICITING PARENTAL INPUT IN PROGRAM PLANNING

Parents should be encouraged to participate in all phases of the Parent Infant Program. Their input, however, is particularly important during the initial assessment and program planning phases.



In this section, the following questions are addressed:

- How can the program manager help parents function as a part of the team?
- What is the Parent Goal Form and how is it used?

HOW CAN THE PROGRAM MANAGER HELP PARENTS FUNCTION AS A PART OF THE TEAM ?

The program manager has the responsibility for involving parents in planning. He/she can help parents feel they are a part of the team by doing the following:

- Review and summarize the results of the initial assessment (the EMI, area by area);
- Encourage parents to ask questions throughout the assessment and development of programming recommendations;

- Explain the step-by-step process of programming (i.e., how the initial assessment is translated into an IPP for their infant) and the reasoning behind it;
- Talk with the parents about the infant's strengths and areas of need as you translate the assessment results to write programming recommendations;
- Be certain that the parents understand all of your work (e.g., talk parents through the formulation of programming goals as you go); and
- Ask the parents to specify "their" priorities for their infant's development and incorporate these into your recommendations.

WHAT IS THE PARENT GOAL FORM AND HOW IS IT USED ?

While the program manager formulates his/her ideas for programming on the programming recommendations document in preparation for the IPP conference, the parents can note their priorities and desires for their infant's program on the Parent Goals sheet (See sample on the next page). Parents are given the goal sheet during the time when the program manager is developing program recommendations. Through their participation in the assessment and through their discussions with the program manager and other team members, the parents should have a good understanding of their infant's skills. The Parent Goals form provides parents with the opportunity to write down their ideas that they would like to express in the IPP meeting. Parents can bring the form with their suggestions and priorities to the meeting to facilitate their input to the planning process. Not all parents, however, will feel it necessary to write down their goals for their infant. However, even if the form is not brought to the IPP meeting, its use helps communicate the program's desire for parental input and stimulates their thinking prior to the IPP meeting.

Sample Form

PARENT GOALS

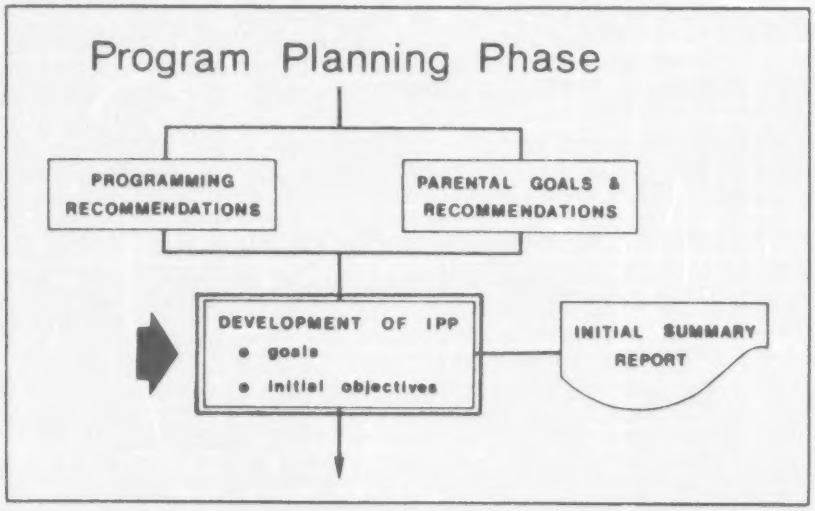
PARENTS: KEEP IN MIND THE FOLLOWING QUESTIONS DURING THE NEXT FEW WEEKS AS YOU WORK WITH PROGRAM STAFF IN ASSESSING YOUR CHILD AND PLANNING HIS/HER PROGRAM. IT MAY BE HELPFUL TO NOTE YOUR CONCERNS AND GOALS AND BRING THEM WITH YOU TO THE PLANNING CONFERENCE FOR YOUR OWN REFERENCE.

1. What skills would you like to work on helping your child develop in the Parent Infant Program this year? Which are most important to you?

2. What skills or knowledge would <u>you</u>, as a parent, like to gain from your participation in the program?

DEVELOPING THE INDIVIDUALIZED PROGRAM PLAN (IPP)

Developing the Individualized Program Plan is the final step in the program planning phase. All of the activities carried out during the initial assessment and programming were designed to lead to this end.



The key questions addressed in this section are:

- What is the IPP and why is it important?
- What is the IPP conference?
- What preparations are necessary for the IPP conference?
- How is the IPP conference carried out?
- How is the IPP completed?

WHAT IS THE IPP AND WHY IS IT IMPORTANT ?

The IPP delineates specific plans for what will be accomplished in the PIP Developmental Classes. It is the basis for working with the infant and his/her family on an ongoing basis and for the evaluation of progress made by the infant toward specific goals.

As a guide for ongoing programming, the IPP:

- Specifies the initial goals and objectives for the infant in each area of development and the resources required, and
- Provides a system for monitoring the start and completion of each objective.

WHAT IS THE IPP CONFERENCE ?

To ensure a quality plan for the infant which reflects the input of team members and parents, a conference is planned which involves all concerned persons. This conference is actually a working session for incorporating everyone's ideas for programming into one comprehensive and individualized plan for the infant,- the IPP.

The conference is scheduled once the program manager has tentative goals in mind for the infant and has had adequate time to discuss these with the parents. The conference participants include:

- The parents,
- The program manager,
- Team members with whom the program manager has consulted during assessment and the development of programming recommendations, and
- Any representatives from the community who have an ongoing interest in the infant's development or the family.

WHAT PREPARATIONS ARE NECESSARY FOR THE IPP CONFERENCE ?

A productive IPP conference reflects careful planning and preparation, particularly by the program manager. Prior to the conference, the program manager should:

- Complete and study the results of the developmental assessment;

- Confer informally with parents, staff members, and other program managers about the infant's assessment results and appropriate goals for programming; and

- Have tentative goals in mind for the infant.

Parents must also be prepared for the IPP meeting. Prior to the conference, the parents should have:

- Participated in the developmental assessment of their infant and discussed the results with their program manager;

- Discussed those areas of their infant's development that concerns them most with the program manager; and

- Completed the form specifying major goals they would like their infant to achieve by the end of the year.

Since other team members are active participants in the conference, they also require preparation to ensure that they:

- Are familiar with the infant's assessment results, and

- Have ideas in mind for possible goals and objectives in their discipline area.

Finally, any community representative planning to participate in the conference should be asked to:

- Share the goals and activities the infant is working on in their program, or

- Communicate their ongoing involvement with the infant/family.

A copy of the "Individual Program Planning Conference" overview should be given to all participants prior to the conference. A sample copy is provided on the next page.

HOW IS THE IPP CONFERENCE CARRIED OUT ?

The IPP conference should last no longer than two hours per family. The meeting should be scheduled after the program manager has:

- Translated assessment results,

- Consulted with team members, and

- Drafted ideas for goals using the programming recommendations document.

The meeting is best scheduled outside the regular Developmental Classes.

Individual Program Planning Conference

I. Meeting Purpose

1. To incorporate parent priorities into the infant's programming.
2. To decide on annual goals for the infant in the various areas of development.

II. Those Attending

Parents, program managers, other team members with different discipline backgrounds, PIP staff, community representative.

III. Preparation for Meeting

PARENTS:

1. Have participated in the developmental assessment of their infant and discussed the results with their program manager.
2. Have discussed areas of their infant's development that they are most concerned about with the program manager.
3. Have completed the form specifying major goals they would like their infant to achieve by the end of the year.

PROGRAM MANAGER:

1. Has completed and studied the results of the developmental assessment.
2. Has informally conferred with parents, staff members, and other program managers about the infant's assessment results and appropriate goals for programming.
3. Has tentative goals in mind for the infant.

OTHER PIP STAFF AND TEAM MEMBERS:

1. Are familiar with the infant's assessment results.
2. Have ideas in mind for possible goals for the infant.

COMMUNITY REPRESENTATIVE:

1. Prepared to share the goals and activities the infant is working on in their program.

IV. Sequence of Activities

1. Introductions
2. Summary of assessment results in each developmental area
3. Come to consensus among parents, program manager, staff, etc. on appropriate goals for the infant
4. Discuss possible objectives and activities appropriate to these goals

During the week when the IPP conference is scheduled, Developmental Classes may be cancelled.

If at all possible, the meeting should be held in a comfortable room where all participants can sit around a table. The atmosphere of the meeting should be kept informal and as comfortable as possible. A blackboard or a flipchart is helpful as a visual aid. The program manager usually leads the conference activities and facilitates discussion among participants. The following agenda is suggested for the conference.

1. *INTRODUCE PARTICIPANTS*

   Each participant of the conference should be introduced and their role/title briefly indicated, ... "John Doe, Michael's father". This can be done by the program manager, or, each person can be asked to introduce himself/herself.

2. *PRESENT AGENDA*

   The agenda for the meeting (i.e., what is to be accomplished) should be briefly stated. By doing this, parents and other participants will know what to expect. The role of each participant should also be indicated. Since the meeting is an important step in the development of the Individualized Program Plan (IPP) for the infant, the IPP purpose and procedures should be clarified at the beginning of the session.

3. *SUMMARIZE PRESENT LEVEL OF FUNCTIONING*

   The program manager should present a brief summary of the results of the EMI in each developmental area. Present and emerging skills should be noted and target areas identified. Much of this information should be available in the programming recommendations document. Any discussion concerning the infant's present level of functioning should be encouraged at this point with the parents. Once the program manager feels that there is a good understanding of the infant's strengths and weaknesses, the discussion should move toward the identification of specific goals.

4. *IDENTIFY GOALS*

   Having reviewed the present and emerging skills of the infant, developmental goals should be identified within each developmental area. At this point, it is advantageous to have a chalkboard or paper large enough to record group decisions on appropriate and desirable goals. One person should act as recorder. The following steps are suggested in this process.

a) *Begin by writing each developmental area horizontally across the board/paper making five columns (i.e., Gross Motor, Fine Motor (Perceptual), Cognition, Communication (Language), and Social). Leave ample space for writing goals below each heading.*

b) *Ask parents which area is of most concern to them. Begin identifying goals in this area. In many cases the area of most concern to parents is Gross Motor.*

c) *Solicit ideas and recommendations for goals in this area. Remember, goals are broad statements indicating the general direction or intent of programming.*

d) *Discuss each recommendation and reach a consensus on its appropriateness.*

e) *Write suggested goals under appropriate area headings. At this point, goals should be stated as broad areas of development on which to work. Goals should, however, be stated as closely to the final form as possible. See the format and sample goals provided below.*

Gross Motor	Fine Motor	Cognition	Communication (Language)	Social
1. Increase head control.	1. Improve ability to grasp objects.	1. Develop awareness of cause-effect relationship.	1. Improve ability to combine syllables.	1. Improve ability to interact positively with unfamiliar adults.

f) *Continue this process until all goals have been identified. Usually, one to five goals are identified in each area.*

g) *Discuss possible objectives and activities appropriate to suggested goals. These may or may not be noted on to board for all to see, but, should definitely be noted by the program manager in his/her notes. Suggestions for objectives should be solicited and discussed at this point even though the actual objectives are not written until after the conference as described in the next section.*

Parental concerns expressed during the meeting should be acknowledged, discussed, and incorporated. The goals for the infant can frequently be derived from these concerns. The program manager should assist parents in expressing their ideas by asking questions, using jargon-free language, and by building upon thoughts expressed by the parents.

5. *BRING CLOSURE TO MEETING*

Once consensus has been reached regarding appropriate goals and suggestions generated, the program manager should summarize the accomplishments of the meeting and ask if there are any additional concerns or questions. A brief summary of the continued development of the IPP should then be given. Indicate that goals will be refined and objectives written for each goal. The IPP will then be reviewed by the parents for the fina. approval and a summary report will be sent to all concerned agencies.

HOW IS THE IPP COMPLETED ?

Following the IPP conference, the program manager, with the assistance of other program managers on his/her team have the task of completing the IPP. The Parent Infant Program's IPP has four parts:

I. Background Data,

II. Summary of Assessment Data,

III. IPP Development and Implementation, and

IV. Program Plans.

In Parts I. through III., pertinent information is supplied by the program manager. This information documents the sequence of events leading up to the IPP and the key participants in its development and implementation.

The most critical part of the IPP is, of course, Section IV. - Program Plans. This section delineates goals and objectives in each developmental area and provides a mechanism for monitoring these throughout the program. One page is used for specifying objectives under each goal, therefore, the number of pages in this section is determined by the number of goals for the infant.

GOALS

Goals identified during the IPP conference may be refined by the program manager, however, the intent of the goal should not change from that agreed on in the meeting.

A goal is a broad statement indicating general direction or intent of programming. They are based on knowledge of sequences of infant development. Several behavioral objectives and activities can usually be derived from one goal. A number of items on a developmental test may be steps toward accomplishing a certain goal.

Some sample goals are provided below.

Sample Goals

1. *Susie will demonstrate head control in prone and sitting.*
2. *Billy will demonstrate awareness of cause and effect relationships.*
3. *Karen will play functionally with toys.*

A goal should be targeted for accomplishment by the infant in a year (i.e., the program year). Using this guideline, goals will reflect shorter or longer range skills depending on the nature and severity of the infant's disability or delay.

OBJECTIVES

An objective is more specific than a goal. The behavior must be described so that another person, given the definition, would look for the exact same behavior. An objective describes intended behavioral outcomes and how these outcomes will be measured. An objective specifies:

1) Who is to accomplish the behavior,

2) The conditions (e.g., cue or prompt, setting, or circumstances) under which the behavior is to occur,

3) A precisely described observable behavior, and

4) The criteria which are acceptable as success (e.g., consistency of response, amount of time to perform task).

Some examples of objectives are provided below.

Sample Objectives (A)

1. *Tony* | *will roll from stomach to back* | *without assistance* | *within 60 seconds*
   WHO | **BEHAVIOR** | **CONDITIONS** | **CRITERION**

   when placed on the floor with favorite object out of reach.
   CONDITIONS

2. *Timmy* | *will sit* | *for 10 minutes* | *with good head and trunk alignment*
   WHO | **BEHAVIOR** | **CRITERION** | **BEHAVIOR**

   with minimal support at hips.
   CONDITIONS

The expected behavior must be stated clearly, but in some cases, conditions and/or criterion are implied. For example, if the criterion of performance is 100% of the time, it does not have to be stated, - or, it can be stated as completed "correctly".

Sample Objectives (B)

1. *Larry* — *will reach into a cup and remove a small object*
   WHO — **BEHAVIOR**
   within 30 seconds on eight out of ten opportunities. *(Conditions implied.)*
   CRITERION

2. *Katie* — *will participate in game playing (involving turn taking)*
   WHO — **BEHAVIOR**
   on three occasions during the day. *(Conditions implied.)*
   CRITERION

3. *Parent* — *will position Michelle in her GM love seat*
   WHO — **BEHAVIOR**
   with proper supports for feeding. *(Criterion implied.)*
   CONDITIONS

Note that the implication must be clear. If there is any doubt, specify the condition or criterion.

Remember, the purpose of writing objectives is to communicate the intent of instruction as simply and as precisely as possible. They should not be allowed to become unnecessarily complicated nor should the process become too time consuming. Practice will improve your objective writing skill.

In PIP, as a general rule, objectives should specify behavior which the infant is likely to be able to accomplish within three months. Progress can be noted within this time frame and thus provides encouragement to the family. Goals which involve longer time periods of imperceptable progress can be very discouraging and should therefore be avoided.

On the next page you will find two excerpts from the Program Plan section of the IPP. In identifying goals and objectives for the infant's program, try to be aware of the "number" that are specified for a given year and keep it appropriate and reasonable for the infant and family. In the IPP, goals and objectives are written for the year, however, not all are

Sample Pages From The IPP

IV. PROGRAM PLANS

DOMAIN:	GOAL:
LANGUAGE	*1. INCREASE MEANINGFUL EXPRESSIVE COMMUNICATION.*

No.	Objectives	Resources/ Consultants	Start Date	End Date	Status	
					Mid	Final
1.1	*Andy will imitate six different actions on cue: wink, snap fingers, blow kiss, wave, honk-honk, pat-a-cake; on two out of three occasions.*					
1.2	*Andy will use three different gestures or movements to indicate wants and needs: point to desired object, arms up for being lifted, turns away for refusal.*					
1.3	*Andy will imitate six different sounds: pa (pat-a-cake), bah (ball), ba-ba (bye-bye), na-na (no-no or night-night), hi, oh-oh, on two out of three occasions.*					
1.4.	*Andy will use sounds or words (no, up) to indicate his wants or needs in two different situations.*					

IV. PROGRAM PLANS

DOMAIN:	GOAL:
FINE MOTOR	*1. REFINE GRASP.*

No.	Objectives	Resources/ Consultants	Start Date	End Date	Status	
					Mid	Final
1.1	*Kelli will pick up a small object between her thumb and first two fingers 75% of observations.*					
1.2	*Kelli will use index finger to probe or point at an object.*					
1.3	*Kelli will pick up a crayon and make a mark on paper 75% of observations.*					

started at the same time. Ideally, objectives are written in sequence so that as lower level objectives are accomplished, others are started. Objectives may also be added to the IPP as programming is carried out. Modifications in objectives may also be made as a result of continued work with the infant and family. In other words, although the IPP should be the plan for the year, there is flexibility to update and modify as appropriate to ensure quality programming. A more formal review of the IPP is carried out at mid-year and involves the parents and program staff in much the same way as the initial IPP conference.

SUPPLEMENTAL SERVICES

Any initial outside service or consultation needs (supplemental services) that were noted on the programming recommendations and/or during the IPP conference should be noted by the program manager on the infant's Individual Record of Supplemental Services. At this phase of the programming, the program manager indicates the priority of each need (e.g., 1= immediate need, 2= needed sometime during the program year, not immediate). For each need that is identified during initial programming, indicate the date on which it was identified. As the program continues, other needs may be identified by program staff and/or parents. All supplemental service needs are dated to avoid later confusion. Once completed, this record should be appended to the IPP and reviewed by the parents. More information on supplemental services is provided in the section on ongoing programming.

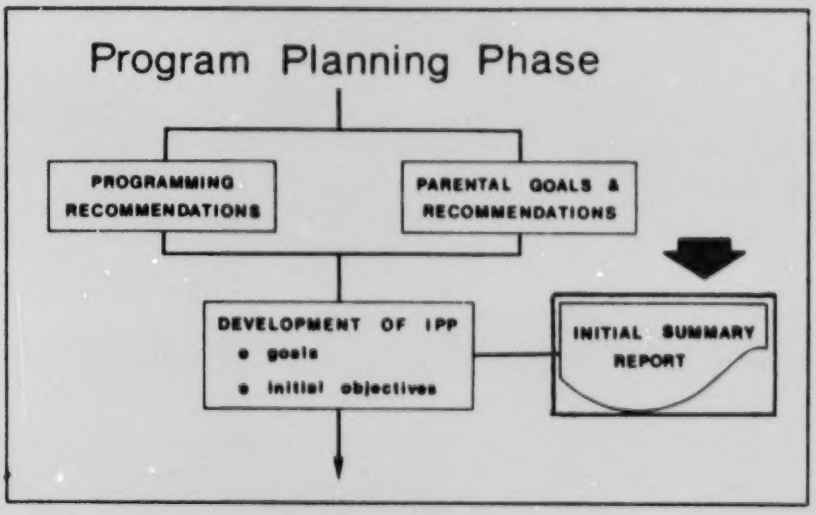
PARENTAL REVIEW

Once the IPP is completed, reviewed by team members, and preferably typed; the program manager should review its contents with the parents. This will most likely to the first time that the parents actually see the document. Therefore, the program manager should review each area of programming, relating goals and objectives to those discussed in the initial IPP conference.

Again, parents should be encouraged to ask questions and make comments. If all is approved, parents can then sign the face page of the IPP and date it. A copy of the signed IPP is given to the parents at the next class session and a copy is made for the infant's notebook. The original should be filed for safekeeping.

INITIAL SUMMARY REPORT

The majority of the IPP phase is devoted to synthesizing information from the initial assessment phase into a plan tailored to meet the needs of the infant. Once this plan (IPP) is complete, the events, data, and plans carried out in these first two phases are summarized in the Initial Summary Report.



The key questions addressed in this section are:

- What is the purpose of the Initial Summary Report?
- What are the contents of the Initial Summary Report?
- What is involved in initial contacts with physicians and agencies?

WHAT IS THE PURPOSE OF THE INITIAL SUMMARY REPORT?

The Initial Summary Report summarizes, concisely and clearly, the:

- Initial status of the infant and family in the program, and
- Plans for ongoing programming.

Specifically, this summary report provides relevant information extracted from the initial assessment and the IPP which can be used in communication

with others concerned with the infant and family, particularly the physician.

WHAT ARE THE CONTENTS OF THE INITIAL SUMMARY REPORT ?

The Initial Summary Report is written by the program manager, or, by an overall Client Services Coordinator and should include the following.

1. *HEADING*

   Indicate the title of the program and report ...

   (Agency Name)
   PARENT INFANT PROGRAM
   INITIAL SUMMARY REPORT

2. *IDENTIFICATION OF INFANT*

   Note name and date of birth (D.O.B.).

3. *DATE OF REPORT*

4. *BACKGROUND*

5. *INITIAL ASSESSMENT RESULTS*

   Give brief summary of results of the EMI in each developmental area. Note skills established and emerging.

6. *SUMMARY OF PROGRAM GOALS*

   Present goals for programming from the IPP in each developmental area. Note any supplemental services planned for the infant/family.

7. *FUTURE PLANS*

   Indicate projected duration of participation in PIP, approximate date of IPP review and assessment, and approximate date of next report.

A sample Initial Summary Report begins on the next page. A copy of the report should be given to the family, physician, and any other outside agency involved with the infant. Be certain that the parents have given written consent for release of information to outside agencies.

OSU

The Ohio State University

The Nisonger Center
1580 Cannon Drive
Columbus, Ohio 43210
Phone 614 422-8365

PARENT INFANT PROGRAM

INITIAL SUMMARY REPORT

Name: Joan
D.O.B. 11/5/78

Date of Report: March 21, 1979

Joan is a 4½ month old little girl diagnosed at birth as having Down's Syndrome and an umbilical hernia (oomphalocele) which was surgically repaired while she was still 'n the hospital. A heart defect has been recently identified.

An initial home visit was made on November 20, 1978, six days after she was discharged from the hospital. The family was enrolled in the Parent-Infant Program at that time. Follow-up home visits were made on December 13, 1978 and January 8, 1979 to provide appropriate home activities to stimulate development until she could attend classes. Assessment was done on 1/17 and 1/24/79, using a videotape for observation of her interests and abilities as well as a developmental assessment.

A parent-staff conference was held on February 12, 1979 to discuss the assessment results and concur on program goals for the program year. A summary of Joan's strengths at the time of assessment are listed below:

Gross Motor

Joan lifts her head when held at an adult's shoulder, makes some crawling movements in prone, and is beginning to attempt to lift her head when lying on her stomach.

Fine Motor

Joan visually fixates on and tracks objects, retains a rattle placed in her hand for brief periods, and holds her hands together when prompted, watching them and occasionally bringing them to her mouth.

Social

Joan reacts positively to comfort, regards faces, is beginning to smile, and appears to discriminate mother from others.

Cognition

Joan responds to familiar voices. She enjoys visual exploration of persons and objects and scratches at her blanket.

Page 2

Joan
D.O.B. 11/5/78

Language

Joan responds to voices and other sounds by increased or decreased bodily activity or looking. She makes small throaty noises, expresses demands by crying and is beginning to make single short vowel sounds.

Based on assessment results, the following goals were dectded upon during the individual programming conference of February 12.

1. Develop good head control in the upright position.
2. Lift her head and prop on elbows while lying on her stomach.
3. Develop ability to roll over.
4. Develop the ability to sit with her head in alignment with her body, when supported.
5. Increase vocalization and other means of communication in amount and variety.
6. Communicate pleasure.
7. Swipe and reach for objects.
8. Increase exploration of objects.
9. Repeat movements to produce an effect.

Joan will continue with the Parent-Infant Program at least through May, at which time a progress report will be provided.

Bettianne Greene Rowe, M.S., O.T.R./L.
Client Services Coordinator

BG/pm
4/7/79

WHAT IS INVOLVED IN INITIAL CONTACTS WITH PHYSICIANS AND AGENCIES ?

The Initial Summary Report should be sent to the infant's primary physician and any other physician that the parents indicate has an ongoing interest in the infant. The Physician Contact letter should accompany the report along with a Reply Form (See examples on following pages.). Additionally, at this time, the physician should be asked to give consent for physical therapy.

Agencies involved in the infant's development should also be sent an initial contact letter, Initial Summary Report, and a Reply Form.

Contacts with physicians and agencies serve two very important purposes:

- They provide specific information regarding the infant and his involvement in the program and solicit involvement of the physician/agency in the process; and

- They increase visibility of the program by bringing it to the direct attention of those persons who are in key positions to identify families and make referrals to the program.

OSU

The Ohio State University

The Nisonger Center
1580 Cannon Drive
Columbus, Ohio 43210
Phone 614 422-8365

THE NISONGER CENTER

PARENT INFANT PROGRAM

PHYSICIAN CONTACT LETTER

Nisonger Center's Parent Infant Program offers weekly developmental classes for Developmentally Disabled or Delayed infants from birth to 3 years of age and their families. We have enclosed a description of the Project to acquaint you, or to bring you up to date, with the Program.

Each of the above noted infant(s) is enrolled in one of our classes. A Progress Report for each child is attached, describing the child's current developmental status, outlining goals in major developmental areas, and noting progress the child has made while enrolled in our Program. We would appreciate any comments or suggestions you might have concerning this programming, including any precautions or contraindications of which we should and may not already be aware. For this purpose we have attached an additional reply form to facilitate your response. Please return this form along with your consent to incorporate recommendations made by Physical Therapy into each child's Program.

We plan to provide you with periodic reports of this kind. Your cooperation is greatly appreciated. If you have questions please contact us at 422-5176.

Sincerely,

Linda Wnek
Project Coordinator

Bettianne Greene
Client Services Coordinator

Enclosures

THE OHIO STATE UNIVERSITY

NISONGER CENTER

PARENT INFANT PROJECT

Physician Reply Form

Child's Name _____ D.O.B. _____

Your Comments, Suggestions:

Signature _____

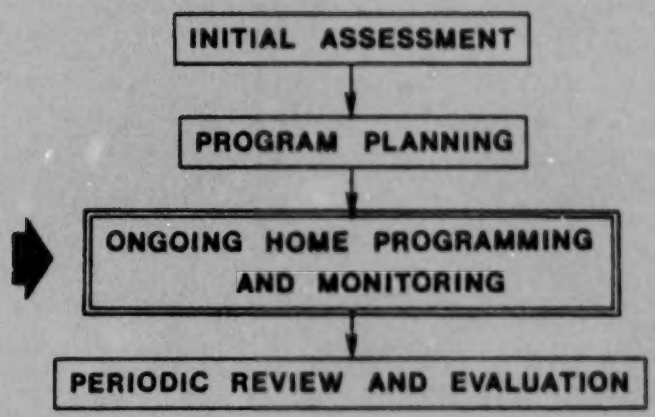
Date _____

Please Return To: The Ohio State University, Parent/Infant Project,
213 Nisonger Center, 1580 Cannon Drive, Columbus, Ohio 43210

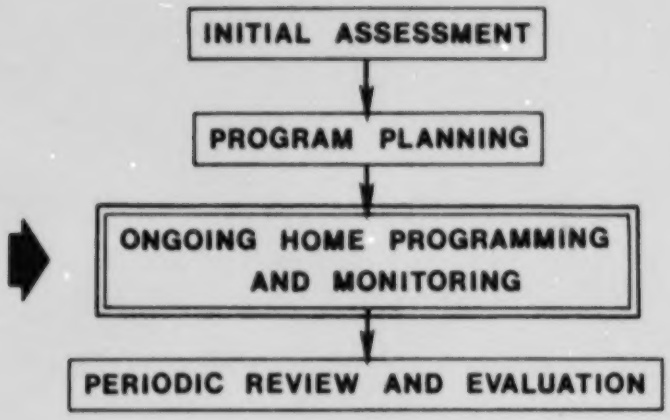
lmc
4/24/79

SECTION

5



ONGOING HOME PROGRAMMING AND MONITORING



INTRODUCTION

After the initial assessment and program planning phases, the Individualized Program Plan is ready to be implemented in the ongoing home programming and monitoring phase.

THE ONGOING HOME PROGRAMMING AND MONITORING PROCESS

The key questions addressed in this section are:

- What is the nature of the ongoing home programming and monitoring phase?
- What steps are involved in the ongoing home programming and monitoring phase?

WHAT IS THE NATURE OF THE ONGOING HOME PROGRAMMING AND MONITORING PHASE ?

Ongoing home programming and monitoring is carried out throughout the program year. It is, in effect, the implementation of the Individualized Program Plan. These plans are refined and carried out and ongoing review of the infant's status is monitored weeekly during the Developmental Classes. Home activities, home visits, and supplemental services are provided which are aimed at accomplishing specific objectives for the infant's development. As infant and family develop, new objectives are established.

WHAT STEPS ARE INVOLVED IN THE ONGOING HOME PROGRAMMING AND MONITORING PHASE ?

The ongoing home programming and monitoring phase involves four major components as depicted in the graphic on the next page. The purpose of each component is:

1. *HOME PROGRAMMING*

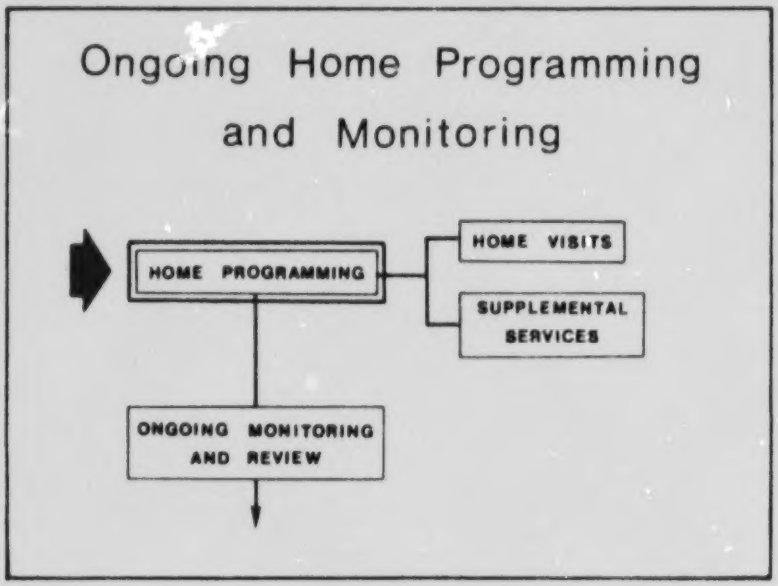
   To provide parents with assistance in carrying out activities at home that are geared toward the accomplishment of specific objectives in the IPP.

2. *ONGOING MONITORING AND REVIEW*

   To enable the program manager and parents to recognize and appreciate the progress made toward the accomplishment of the IPP objectives.

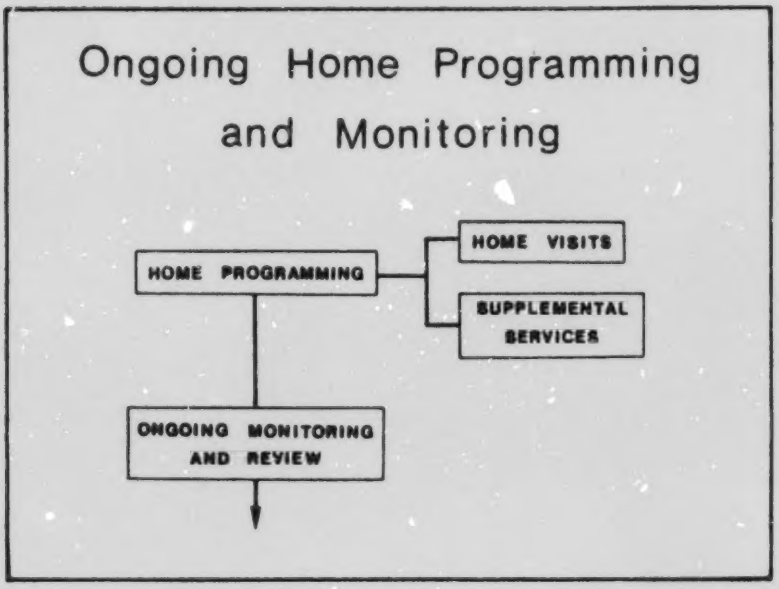
ONGOING HOME PROGRAMMING

During the initial weeks of the family's participation in PIP, assessment and program planning are completed to provide a basis for ongoing work with the infant and the family. Ongoing programming involves the weekly assistance given to parents in carrying out activities at home that are geared towards the accomplishment of specific objectives in the IPP.



The key questions addressed in this section are:

- What are home activities?
- What is the Home Activity Sheet?
- How are home activities written?
- What considerations should be made in developing a home program?
- What resources are used in developing home activities?



3. ***HOME VISITS***

To provide continuity between the program setting and the home environment.

4. *SUPPLEMENTAL SERVICES*

To provide a broad range of services to the infant and parents in addition to those provided by the program staff.

WHAT ARE HOME ACTIVITIES ?

Home activities are specific strategies designed for the family to carry out with the infant at home that are geared toward the accomplishment of specific objectives in the IPP. These activities, or intervention strategies, specify the "how to's" for parents and for others working with the infant. Since the effectiveness of the PIP is determined to a large extent by the follow-through of stimulation activities by the parents/family throughout the week at home, the home activities that are developed by the program manager are extremely important to quality programming in the Parent Infant Program.

WHAT IS THE HOME ACTIVITY SHEET ?

The Home Activity Sheet provides a means by which program managers and consultants can communicate (in writing) their suggestions for home programming to the parents. The form is in duplicate. The carbon copy goes to the parents. The original should be filed in the infant's folder for ongoing use in the Developmental Classes. These instructions serve as a reference for parents throughout the week for home activities and will facilitate a parent's communication of the activity to other members of the family, other caregivers, or other service providers. They also constitute a record of home programming for future reference by other programs the infant may enter.

HOW ARE HOME ACTIVITIES WRITTEN ?

Once objectives are specified in the IPP for the infant and/or family, activities may be developed to facilitate the accomplishment of these objectives. The Home Activity Sheet provides the format for developing these activities. Sample Home Activity Sheets are provided on pages 5-7 and 5-8.

In writing a home activity, several components should be considered as they appear on the Home Activity Sheet.

1. *IDENTIFYING DATA*

   Indicate the infant's name and the name of the program manager. Specify the start date (i.e., the date on which the activity is sent home with the parents).

2. *OBJECTIVES*

   Indicate the specific objective(s) for which the activity is written. Use the objective number(s) from the IPP. Ideally, the activity suggested for the parent(s) should support more than one objective, however, there may be instances in which an activity is specific to only one objective. Objective numbers should always be preceded by a letter indicating their developmental area (e.g., C for cognitive, GM for gross motor, FM for fine motor,

L for language, and S for social).

3. *ACTIVITY*

Provide a concise statement of the activity that is to be carried out.

4. *PURPOSE*

This is probably the most important part of the form. It calls for an explanation of the rationale behind the activity to be written so that the parent understands the purpose of what is suggested and is motivated to follow through at home.

5. *PROCEDURES*

Provide concise, yet detailed, instructions for carrying out the suggested activity. The instructions should clearly state verbal and/or nonverbal cues to be given by parents, parental responses to both desirable and undesirable infant responses, and what constitutes a "correct" and "incorrect" response by the infant. Illustrations should be used if they help to clarify the instructions (See example page 5-8.). Write instructions in a step-by-step form so that they are easily followed. Avoid unnecessary verbage and jargon. Any variations to the activity which can be tried by the parents should be noted.

6. *MATERIALS NEEDED*

List any special materials or equipment necessary or helpful in carrying out the activity. This helps to ensure that the parents understand the activity and have the means available to follow through at home.

7. *SETTING*

Further define the activity by suggesting when, where, and by whom it would be most appropriately carried out (e.g., whether it is a handling technique that should be practiced by all caregivers at any time the opportunity arises or a feeding program to be practiced by the mother at lunch time).

8. *DISPOSITION*

When the activity is discontinued, specify the end date and check whether the infant has achieved the skill or if, for some reason, the activity has been revised or terminated. Further explanation of the disposition should be noted in "Comments".

Sample Home Activity (1)

Parent-Infant Project Home Activity Sheet

Child: Kimberly Krasney

Program Manager: N. Nevil

Start Date: November 22, 78

Objective(S): G.M. 1: Pivot prone 360 degrees from either left or right. F.M.1develop fingertip prehension. F.M. 3 fingerfeed self 10 bites at meal

Activity: Kim placed on stomach and required to turn herself to obtain small edibles which she will then be encouraged to pick up and put into her mouth.

Purpose: This activity is designed to develop the movement of pivoting to get things in addition to refining the grasp necessary to pick up and eat finger foods.

Procedures:

1. Place Kim on a smooth surface lying on her stomach.
2. Play a game with her by placing a flat dish in front of her with small, favored edibles will be very visible. Move the plate out of her reach to either side and down by her hips.
3. Help Kimberly bend her hip and knee on the opposite side of her body while continuing to entice her with glimpses of the food, and then returning it to its former position.
4. Once she begins to move, continue to move the food away from her, encouraging her to move in a circle.

** 5. Initially, the first movement should be rewarded with her obtaining or edible. Assist her in obtaining ard getting into her mouth making sure she does not roll over.

6. Gradually, require her to increase the distance from one to two, then three movements, or 30 degrees, 60 degrees, 90 degrees, in order to obtain the edible.
7. After completion of successive steps, require 180 degree or semi circle for edible. Make sure pivoting is completed to both sides.

Materials Needed: Flat dish with edges, small edibles (pieces of crackers, cookie or cereal)

Setting (Time & Place): Floor with smooth surface preferably when Kalli is hungry.

End Date 11/28 ☒ Achieved ☐ Revised ☐ Terminated

Comments: _____

The Ohio State University
Form 0000

Sample Home Activity (2)

Parent-Infant Project Home Activity Sheet

Child: Carrie Cline **Objective(S):** Will be properly positioned

Program Manager: Agatha Gates in sitting.

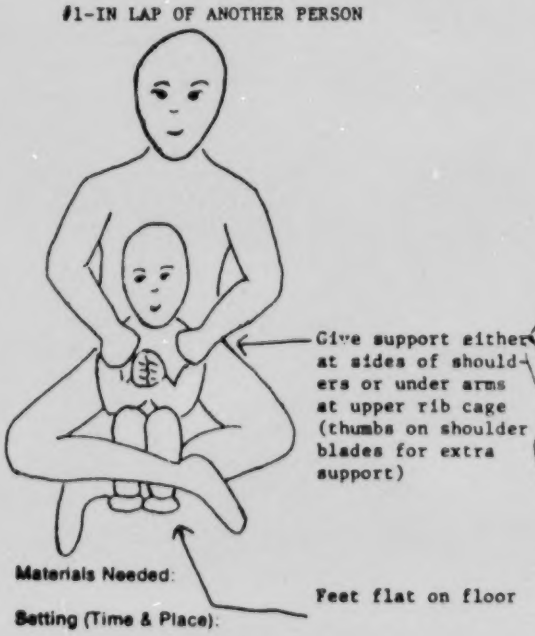
Start Date:

Activity: Positioning of Carrie in sitting.

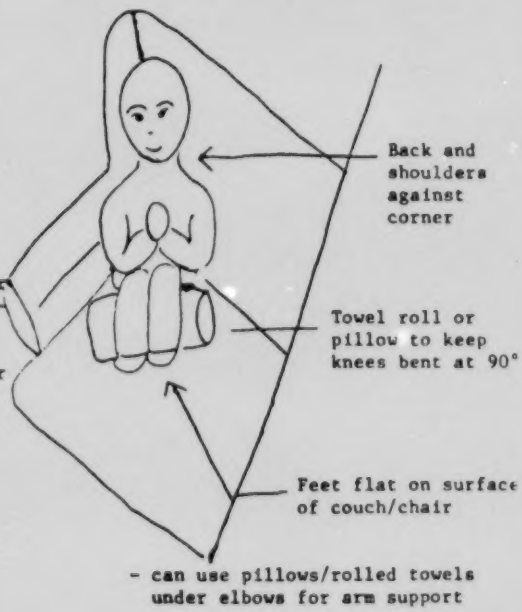
Purpose: To promote a comfortable and relaxed position in order to enable Carrie use arms and hands in activities.

Procedures:

#1-IN LAP OF ANOTHER PERSON


Give support either at sides of shoulders or under arms at upper rib cage (thumbs on shoulder blades for extra support)
Feet flat on floor

#2-CORNER OF CHAIR OR COUCH


Back and shoulders against corner
Towel roll or pillow to keep knees bent at 90°
Feet flat on surface of couch/chair
- can use pillows/rolled towels under elbows for arm support

Materials Needed:

Setting (Time & Place):

End Date ☐ Achieved ☐ Revised ☐ Terminated

Comments:

The Ohio State University
Form 3143

WHAT CONSIDERATIONS SHOULD BE MADE IN DEVELOPING A HOME PROGRAM ?

The home activities suggested for the parents constitute the infant's home program. Typically, one activity sheet is used for one activity and parents are provided a variety of activities to work with at any one time. The nature and number of home activities provided depends on several factors.

FAMILY CIRCUMSTANCES

Home activities should reflect consideration of family circumstances. In families where parents both work outside the home, consideration should be given to the parental time available with the infant and to substitute caregivers. Some parents may express a desire to have a number of different activities that they are able to incorporate in their daily interactions with the infant. Others may want more structured and fewer activities. Home activities written for other caregivers that are with the infant during many of his/her working hours should be written very simply and should have diagrams and illustrations to help communicate the activity clearly.

PARENTAL ATTITUDES

Consideration should also be given to parental attitudes and parenting styles in writing home activities for the family. Here, a keen sensitivity for what "kind" of assistance parents need and what will translate into optimal stimulation for the infant is important. Some parents appear to have an unending desire to have more activities to do with their infant and appear (from your observations and their reports) to be so structured in their interactions with their infant that there is little mutual enjoyment and satisfaction. These parents may be unknowingly substituting the program's structured learning interactions for the mutually satisfying play interactions that are so critical to the infant's and the parent's developing sense of competence. In such cases, activities may best be written with less structure and should be incorporated in the daily play with and nuturing of the infant, rather than as a special learning "task".

Other parents may need more structure in that they appear to have difficulty in following through with suggestions at home. Still others may appear to be "distant" and have difficulty relating affection to the infant. This is certainly not uncommon, particularly during the early months. Under these circumstances, activities should be written which provide greater opportunity for intimate contact and for enjoyment on the part of both infant and parent.

All parents are different. Within a family, fathers interact differently with the infant than do mothers. It is important for the program manager to be sensitive to how each parent interacts with the infant and how he/she feels about this interaction.

THE INFANT'S FUNCTIONING

In writing home activities, consideration should also be given to the infant's level of functioning and anticipated rate of progress. If the infant is making

steady progress, the program manager may be less concerned with providing a lot of variety in the home program in that new activities will be written to replace ones that the infant has outgrown. However, for the infant whose progress is minimal, the program manager must be more creative. A variety of different activities may be suggested to parents in working toward the same objective. Otherwise, parents can become frustrated and may feel that no progress is being made.

SUMMARY COMMENTS

In ongoing home programming, home activities should be tailored to the family, reflecting the individual needs of the parents as well as the infant. Parents should contribute to the development of the home activities. They may input into the procedures for carrying out the activities as well as any suggested variations in activities that are appropriate.

Feedback from parents on home programs should be sought on a weekly basis during the Developmental Classes. Any modifications that are indicated should be noted directly on the form. When major changes in home programs are indicated, the activity should be re-written in a new form to avoid confusion.

Parents may want to make notes during the week concerning the home program that will assist them in providing accurate feedback to program managers during the Developmental Classes. Parent notes can be kept on an attached sheet of paper.

WHAT RESOURCES ARE USED IN DEVELOPING HOME ACTIVITIES ?

The Parent Infant Program does not rely on any one curriculum or resource for activities. There is no one curriculum that can be used with all infants. In addition, it is felt that the use of a particular curriculum may lead to lack of creativity on the part of the program manager.

There are a number of excellent resource materials available from which ideas for activities for infants can be gleaned. Any one program will have a different assortment of these. The responsibility of the program manager is to become familiar with the curriculum resources available to them so that they can be used more easily during the ongoing programming. Several that are particularly good for working with infants are annotated in the bibliography located in the appendix of this manual.

Most of these resources provide very specific stimulation activities that are geared toward the development of a specific skill (e.g., sitting). There is considerable overlap in the specific target skills from one resource to another, after all, milestones of normal development are fairly well defined. Differences lie in the specific activities that are suggested for the attainment of these milestones.

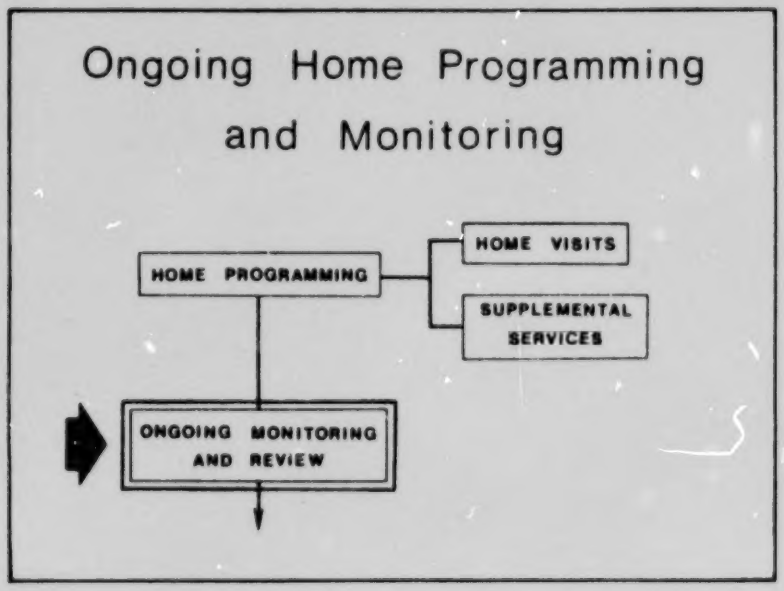
In using available resources, the program manager has the task of tailoring activities to the infant and family with whom he/she works. In some instances, activities may be found in these resources that are appropriate for the infant with no modifications needed. More commonly, activities need to be broken down into smaller steps for the infant so that progress can be appreciated. Or, for the more impaired infant, modifications may be needed which incorporate special handling needs and which consider the specific limitations of the infant.

The task of the program managers, then, is to use the programming resources available to them for "ideas" for activities for their infants. And, by making programming resources available to parents, they too can contribute to ideas for activities for their infant.

In addition to written curricular materials, team members and other consultants are also sources of ideas for activities. For example, a physical or occupational therapist will assist a program manager without this background in developing handling and positioning suggestions for the infant. A team member whose background is psychology or child development may have ideas for problem solving activities for infants with very limited motoric functioning. Consulting with team members on the development of home activities is a process that continues throughout the duration of the program.

ONGOING MONITORING AND REVIEW

As the family implements suggested activities at home with the infant, progress is hopefully made toward the accomplishment of specific objectives written for the infant in the IPP. In order for parents and program managers to truly recognize and appreciate progress made by the infant, it is important for the program manager to monitor the infant's behavior over time. This is done on an ongoing basis during the weekly contact with infant and family in the Developmental Class.



The key questions addressed in this section are:

- What are objective progress notes,
- How are progress notes made?
- What is a baseline?
- What are general progress notes?

WHAT ARE OBJECTIVE PROGRESS NOTES ?

Objective progress notes are used by the program manager to make ongoing notes on the infant's progress. The forms used for these notes are color coded for each major area of development corresponding to that of the EMI assessment. The notes may be filed in the IPP following the goals and objectives of each developmental area. Or, they may be filed separately in the infant's Working File.

HOW ARE OBJECTIVE PROGRESS NOTES MADE ?

Ongoing notes should be kept by the program manager on progress for each objective toward which the infant is working. As shown in the example on the next page, progress notes should include the following.

1. *DATE*

   Every entry made should be dated.

2. *OBJECTIVE NUMBER*

   The number of each objective (from the IPP) should be indicated to identify the notes made (e.g., GM 1.1). All observations noted should refer to a specific objective written for the infant.

3. *OBSERVATIONS*

   Brief, concise notes should be entered on observations of the infant's behavior. In making observations, the program manager should specify the exact response made by the infant, indicating both quantity and quality of the response (e.g., "sat unassisted, back slightly rounded, for approx. 5 seconds, then fell backwards"). Any specific cues given or materials used should also be indicated if relevant to the description of the infant's response. Progress should be checked on a particular objective at least once every two or three weeks.

WHAT IS A BASELINE ?

The first notation recorded for each objective should be a baseline. The baseline describes the infant's level of performance with respect to an objective at the time when the objective is written. In other words, it provides the program manager and family with a "base" against which ongoing functioning of the infant can be compared. It is the starting point which indicates where the infant was when the objective was written.

As with all entries to the objectives progress notes, the baseline should be concise and should specify quality and quantity of behavior as depicted in the example on the next page.

Sample Objective Progress Notes

OBJECTIVE PROGRESS NOTES

COGNITIVE

Date	Obj. No.	Observations
12/6/79	C1.1	BASELINE: WHILE IN SUPPORTED SITTING POSITION,
		PETE WILL OBSERVE THE OBJECTS (RATTLES, ETC)
		REACH AND GRASP. THE OBJECT GOES
		IMMEDIATELY TO HIS MOUTH WITH NO EX-
		AMINING OR FEELING. HE EXAMINES
		OBJECTS MUCH BETTER WHILE SIDELYING.
1/10/80	C1.1	PETE WILL MOVE SLINKY UP AND DOWN AND
		WATCH IT MOVE WHEN IN SUPPORTED
		SITTING POSITION AND WILL MOUTH IT
		FOR ≃ 1 MINUTE.
2/25/80	C1.1	HOME VISIT: MOM REPORTS EMERGING TRANS-
		FER OF OBJECTS. SAW PETE FINGER
		PLASTIC WRAPPER TO MAKE SOUND,
		SHAKE KEYS, EXAMINE OBJECTS
		VISUALLY, AND USE OR BOTH HANDS
		TO GRASP AND PULL OR SCRATCH AT
		TOY FOR 2 MINUTES.

HOW ARE GENERAL PROGRESS NOTES MADE ?

General progress notes are recorded on a separate form, as necessary, to document essential information that does not pertain to progress on current objectives. These notes should be factual and concise. Types of information that should be recorded include:

1) Brief summary of events of home visits, either for initial intake or ongoing to provide program continuity,

2) Summary of the content of formal parent and staff conferences,

3) Informal communications with parents regarding concerns related to their infant or other relevant family circumstances (e.g., reasons for missed classes),

4) Responses given by the staff regarding specific parent concerns,

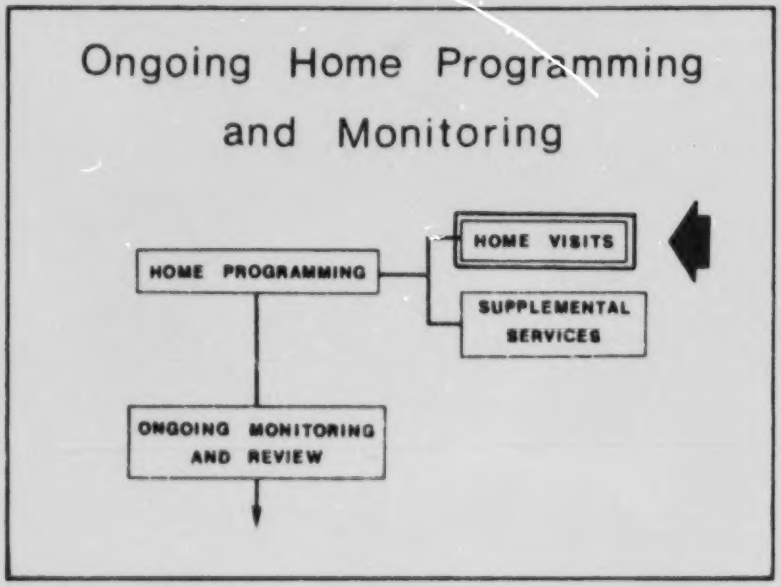
5) Communications either sent to or received from the infant's physician(s) or other professionals working with the family,

6) Changes in the infant's medical status diagnosis or any diagnostic or corrective procedures to be performed, and

7) Client disposition when discharged from the PIP (e.g., future placement in programs, etc).

HOME VISITS

Home visits are an important component of the ongoing home programming and monitoring phase.



The key questions addressed in this section are:

- How can ongoing home visits compliment the Developmental Classes?
- How should a home visit be conducted?
- What behaviors should be avoided in home visits?

HOW CAN ONGOING HOME VISITS COMPLIMENT THE DEVELOPMENTAL CLASSES ?

After the initial home visit, families attend the regularly scheduled Developmental Classes. Ongoing home visits compliment these classes in several ways.

1. *THEY PROVIDE CONTINUITY BETWEEN THE PROGRAM SETTING AND THE HOME*

   Home visits are useful as a means of providing continuity between the program setting and the home environment. Often, activity suggestions or certain techniques for physical or behavioral management are not smoothly integrated in the home since there are more variables to contend with. The program manager can reinforce the parent behavior at the time or suggest appropriate modifications with parent input. It is often beneficial to see the equipment and/or play materials being used at home to ensure that the infant's response to the home activities is the one desired and that his/her body position is optimal for best functioning.

2. *THEY PROVIDE A MORE NATURAL, ANXIETY-FREE ENVIRONMENT FOR THE OBSERVATION OF INFANT BEHAVIOR*

   Some infants are not at their best during the class sessions for a variety of reasons (e.g., not the best time of day, react negatively to strange environment, stranger anxiety, too many distractions, etc.), and their true level of ability can more readily be seen when they are at home in a familiar and comfortable setting. The infant may eventually overcome his/her reactions, but in the meantime, both family and program manager will work together most effectively with periodic supplemental home visits and appropriate programming can be maintained.

   Family and infant interaction may also be observed more accurately in the home than in the classroom setting. With this knowledge, the program manager can often suggest activities more suitable to the family style and positive interactions can be capitalized upon and reinforced.

3. *THEY PROVIDE THE OPPORTUNITY TO HELP FAMILIES "CATCH UP" IN CASES OF ABSENCE FROM THE FORMAL SESSIONS*

   Home visits to serve a family whose attendance is sporadic may not be the most desirable option. This may tend to communicate that irregular attendance is

acceptable since home visits are provided anyway. However, in cases of absence due to illness or other family circumstances, a "catch up" home visit may reassure the family that the program is interested in them and their infant and supports the idea that regular participation in important.

In addition, parent(s) may request a home visit with a specific purpose in mind. Regardless of the purpose(s) of the home visit, most families benefit from quarterly visits. If the family seems to rely on the home-based aspect of the program as their primary contact with the program manager, this should be discussed with them so that the most suitable type of intervention can be implemented. If the class format does not meet their needs, perhaps an alternative mode of service can be developed in which greater continuity and carry-over can be sustained.

HOW SHOULD A HOME VISIT BE CONDUCTED ?

The following suggestions offer some practical guidelines for interaction with parents for both initial and ongoing home visits.

1) Make all necessary preparations prior to the visit. Use the following list as a guide.

   - Arrange a time which is convenient for you and the family when the infant is most likely to be alert.
   - Confirm your visit approximately 24 hours in advance.
   - Be certain that you have all information/resources necessary to carry out an effective home visit.
   - Let the family know the purpose(s) of your home visit and determine whether it agrees with their needs and expectations.
   - It is often helpful to have a written plan or outline of what you want to accomplish available for easy reference so you do not overlook an area of concern.
   - Bring any additional resource materials you want to share with the family (e.g., books, activity suggestions, play materials, or equipment).

2) As you get to know the family, you will become acquainted with their strengths and needs. When you arrive, be alert to the emotional overtones or mood of the family members.

If they seem tense, it is often best to try to draw this out (e.g., "You seem tired, tense, worried, etc." "How has your day gone?" "Would it help to talk about it for a minute/"), rather than try to overlook it and concentrate on working with the infant. Often, very little of value is accomplished when working in a tense atmosphere. Similarly, it is also helpful to comment on positive aspects of the setting, parents' attitudes, etc.

3) Assess relevant factors in the environmental setting and suggest modifications when appropriate. For example, discussion with parents or work with the family and infant often proceeds best in an atmosphere with as few distractions as possible. Going to a smaller area, removing unneeded play items, turning off the television or radio, or redirecting siblings when they are disruptive; can help everyone to attend to the particular activity or interactions more easily. Dirty dishes may have no bearing on the interaction, but your attitude about them could very well have an effect.

4) Remember that the parents and other family members know their infant best. Always seek their input, their impressions or suggestions and incorporate them in the program plan. Avoid making value judgments!

5) Be sensitive to verbal and behavioral messages. Deal with the issues at hand, at the time, whenever possible. Parents, as well as siblings, are at some point or points along the continuim of adjustment to the addition of another family member as well as to the effects of the developmental disability. We would be wrong to assume that they are constantly in emotional turmoil or that they always feel that they can cope effectively.

   Often, individuals in the family do not share the same feelings or outlook. They may be able to accept one another's different perspectives, or this may be a cause of disharmony, decreased communication, or inability to work together effectively. The home visitor may be able to assist family members in communicating by empathetic listening, reflecting their comments to them, and discussing alternatives or options, rather than sympathizing, giving opinions, or making decisions for the family. Open discussion in an atmosphere of acceptance can help the family members draw on their own reserves for coping and problem solving or to reevaluate their feelings and expectations.

6) It is often helpful to verbally summarize the events and accomplishments of the home visit and clarify any further points that need continued attention.

7) Write a note summarizing the home visit and any details that need follow-up or further action.

WHAT BEHAVIORS SHOULD BE AVOIDED IN HOME VISITS ?

The following behaviors should be AVOIDED in home visits!

1) Dominate the conversation. (Instead, be a sensitive listener.)

2) Do all interaction with or handling of the infant. (Since the parent(s) are the ones who will be carrying out the program and they know their infant best, encourage them to try things or demonstrate activities.)

3) Make assumptions. (Assumptions are often based on incomplete information and the parent(s) or sibling(s) may not have an opportunity to express themselves.)

4) Ignore the parent(s)'/sibling(s)' communications whether verbal or nonverbal. (Try to deal with them at the time.)

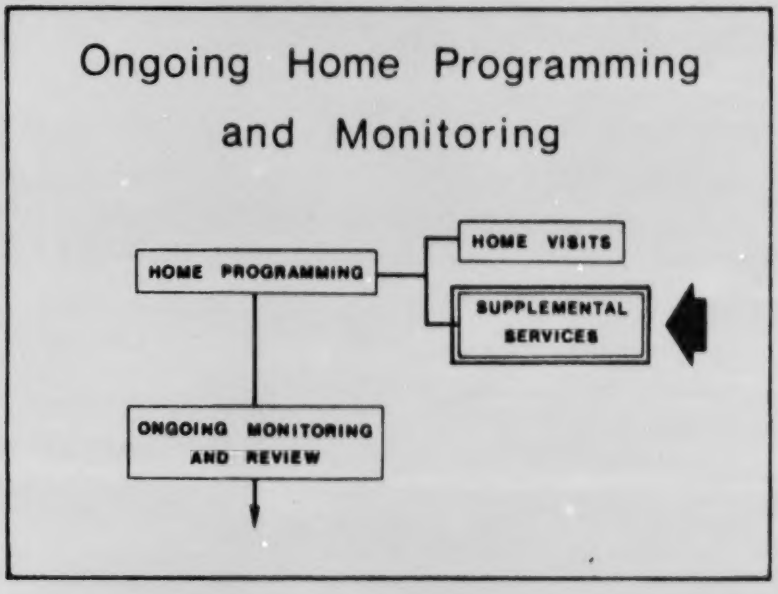
5) Be afraid to admit that you don't have an answer. (Consult with a resource person who may be able to provide constructive information or suggestions.)

6) Give pat answers to parents' questions and concerns. (The program manager does not have to feel the responsibility of solving all problems or making everyone feel cheerful and "alright".)

7) Stay longer than originally discussed with the parents. (They have other plans also.)

SUPPLEMENTAL SERVICES

In addition to those areas of expertise represented by the program staff, the development of resources can be an effective adjunct in the provision of broad-range services to families who have a developmentally disabled infant. Either the program manager or the family may identify one or more concerns which warrant more indepth assessment or treatment. Supplemental services should be part of the infant's individualized program plan.



The key questions addressed in this section are:

- How are supplemental services identified?
- What is the Supplemental Services Record?
- What other benefits can supplemental services have for PIP?

HOW ARE SUPPLEMENTAL SERVICES IDENTIFIED ?

Having completed the initial assessment and the individualized program planning conference, the program manager can identify necessary supplemental services and determine which are immediate priorities and which require consultation that can be scheduled later in the program year. Resources that compliment services already provided in the Parent Infant Program include:

- Nutrition,
- Occupational therapy,
- Physical therapy,
- Clinical counseling,
- Social work,
- Dentistry,
- Physical medicine,
- Optometry or opthalomology,
- Neurology,
- Audiology,
- Nursing,
- Language/communications therapy, and
- Psychology.

WHAT IS THE SUPPLEMENTAL SERVICES RECORD ?

The Supplemental Services Record is used to record:

1) Needed resources,
2) Priority for scheduling the services (i.e., immediate or secondary priority),
3) Dates service is scheduled and accomplished,
4) Person(s) involved in providing the supplemental services, and
5) Any follow-up contacts with the resource.

Review the sample Supplemental Services Record on the next page.

Sample Supplemental Service Record

INDIVIDUAL RECORD
OF SUPPLEMENTAL SERVICES

Child _____ **D.O.B.** _____ **Year** _____

Service	Needs		Service Scheduled (date)					
	Priority*	Date**						
Audiology								
Language								
Nursing								
P.T.	1°	3/15/79	APRIL - MAY 1979					
O.T.	1°	3/15/79	4-79					
Psychology								
Behavior Mod.								
Social Work								
Optometry	1°	4/1/79	Referred by Dr. Ray					
Dentistry								
Physical Medicine	1°	4/1/79	Dr. Alexander 4/20/79					
Neurology	2°	4/1/79	Family Made apt w. Dr. Ray					
Feeding/ Nutrition	1°	4/1/79	5/8/79	2/28/80				
Adaptive Seating	1°	1/1/80	2/10/80 Completed on	4/15/80				
Other (Specify)								

*1 - immediate; 2 - needed during program year, not immediate

**Date need was identified

The Supplemental Services Record should be kept in the infant's Working File so that it can be referred to as the need arises. As the program manager works with the infant and family throughout the program, additional needs for special consultation and/or outside services may be identified.

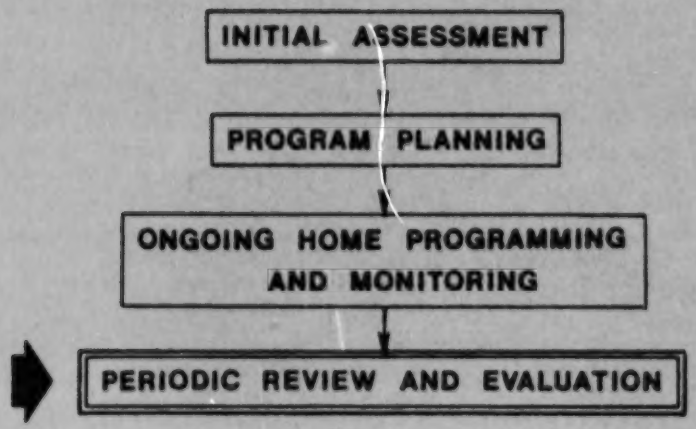
WHAT OTHER BENEFITS CAN SUPPLEMENTAL SERVICES HAVE FOR PIP ?

Developing contacts with relevant professionals or agencies in the community for provision of supplemental services can be a definite asset to the program. For example:

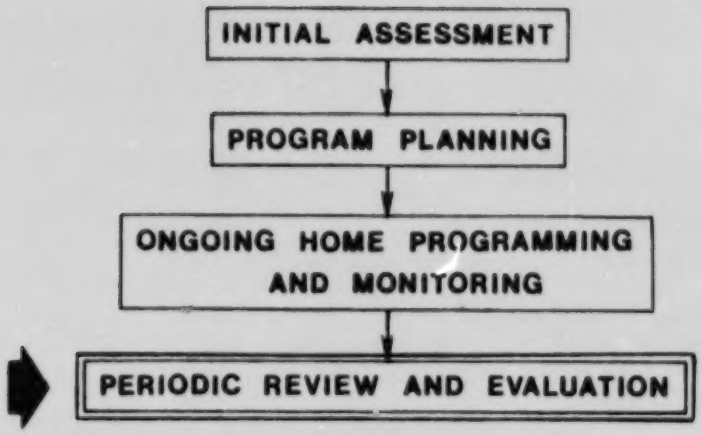
- The number of services available for referral (which have experience in working with developmentally disabled infants) is expanded,
- Obtaining services becomes a relatively centralized process which tends to reduce duplication and confusion, and
- A working relationship may lead to closer involvement with the program and possible referrals.

SECTION

6



PERIODIC REVIEW AND EVALUATION



INTRODUCTION

In any worthwile endeavor there is a need to step back and take a serious look at the results and impact of one's efforts. So it is in providing program services to the family with a developmentally disabled or delayed infant. Important questions can be raised: What effect have program efforts had on the infant? On the parent(s)? On the family? On others in the community? How can program services be improved upon in the future? These questions are addressed in the final phase of the Parent Infant Program process -- Periodic Review and Evaluation.

PERIODIC REVIEW AND EVALUATION

The key questions addressed in this section are:

- What is the purpose of periodic review and evaluation?
- What is involved in periodic review and evaluation?

WHAT IS THE PURPOSE OF PERIODIC REVIEW & EVALUATION?

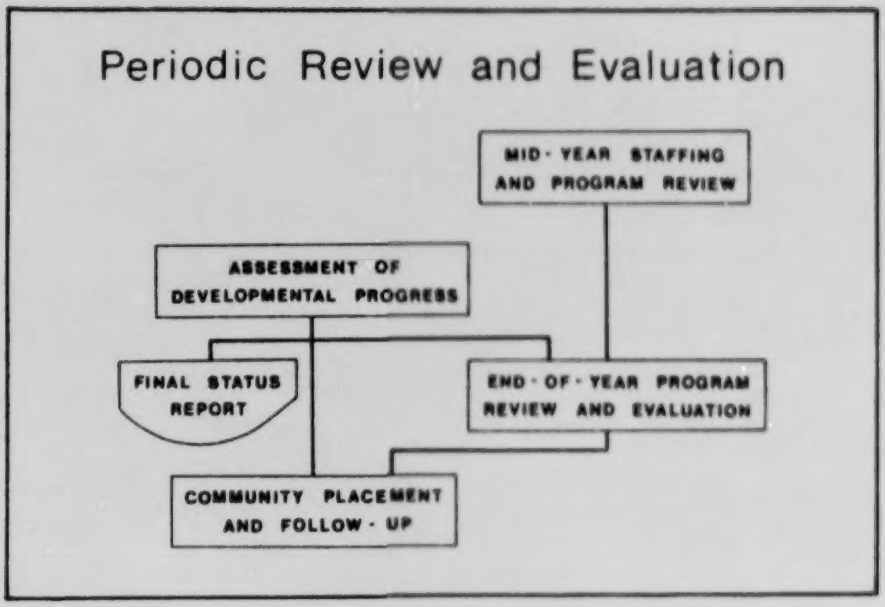
In order to insure quality programming to families, periodic review is necessary. This review and evaluation takes place at specific times during the program year and should provide parents and program staff information needed to make decisions concerning future programming for the infant and family.

It also provides a mechanism for assessing the impact of the PIP intervention as it can be measured through parental feedback and child progress. This information, while of limited use to ongoing programming for the family may be of some value to programs that would like to communicate the results of their efforts to the outside community.

WHAT IS INVOLVED IN PERIODIC REVIEW & EVALUATION?

Periodic assessment and evaluation begins at the time of entry of the family in PIP, or at the beginning of the program year, and continues through the end of the year, or to the time of exit from PIP. Thus, it is a phase that runs through all phases of the program process discussed in the previous sections.

Specifically, periodic Review and Evaluation in the PIP model involves the activities depicted below:

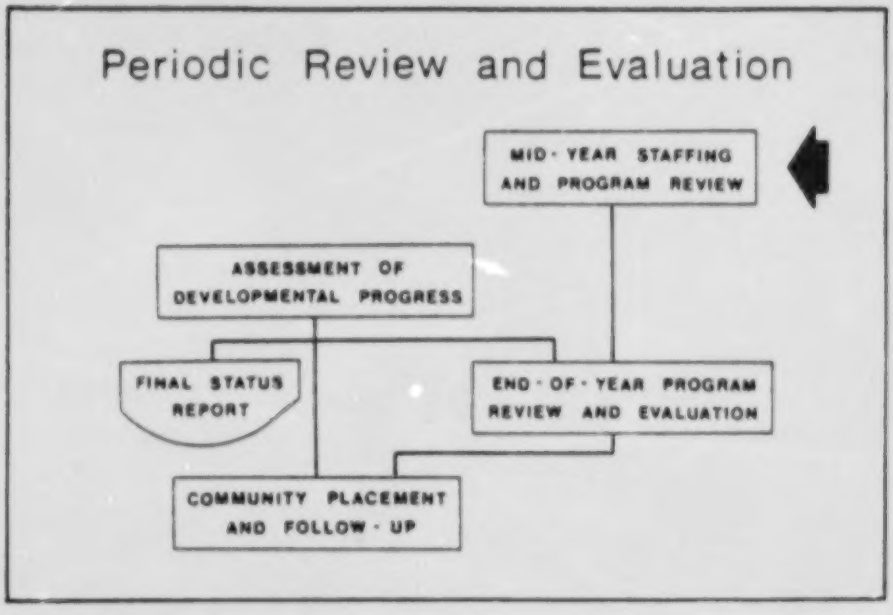

Periodic Review and Evaluation
MID-YEAR STAFFING AND PROGRAM REVIEW
ASSESSMENT OF DEVELOPMENTAL PROGRESS
FINAL STATUS REPORT
END-OF-YEAR PROGRAM REVIEW AND EVALUATION
COMMUNITY PLACEMENT AND FOLLOW-UP

MID-YEAR STAFFING AND REVIEW

While monitoring and updating of objectives written for the infant and family is ongoing in the Developmental Classes, there is a need to set aside a specific time for reviewing with parents:

1. progress made on objectives
2. modifications needed in programming, and,
3. future programming needs and direction

This is best carried out in a separate meeting with the family and program staff at a mid-point in the program year. The mid-year staffing with parents has definite value to maintaining quality programming for the parent and infant.


Periodic Review and Evaluation
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ASSESSMENT OF DEVELOPMENTAL PROGRESS
FINAL STATUS REPORT
END-OF-YEAR PROGRAM REVIEW AND EVALUATION
COMMUNITY PLACEMENT AND FOLLOW-UP

Key questions addressed on this section are:

- What is the purpose of the mid-year staffing?
- How is the mid-year staffing conducted?

WHAT IS THE PURPOSE OF THE MID-YEAR STAFFING?

During the weekly sessions with the parents and their child, periodic informal updating of the child's status can be made. A formal meeting specifically for the purpose of review of the child's program can serve several functions:

1. It is an opportunity to review the child's documented behavioral objectives.

2. Parents and staff can confer with one another regarding the continued appropriateness of the goals and objectives stated in the IPP and the possible need for alterations to meet the current needs of family and child.

3. Parents may wish to discuss their expectations and desires for the future development of their child.

4. The parents/staff may discuss the rationale behind the objectives and related home activities as a viable intervention strategy for them.

5. Staff can again reinforce the parenting strengths in the family and hopefully assist the family in maintaining a perspective of their efforts and feelings related to raising a child with a developmental disability.

6. Parents may have specific questions related to medical management of their child's condition or their home program; or, their questions may be of a more general nature; i.e., "how does my child compare with others who have this disability?".

HOW IS THE STAFFING CONDUCTED?

Attending the mid-year staffing should be both parents, the Program Manager, at least one member of the team, and any community agency personnel involved with the family on an ongoing basis. The staffing should be scheduled at a mid-point in the program year and should be held in a comfortable room with a table. The staffing should not usually exceed two hours and may or may not replace the weekly Developmental Class session with the family. It is a good idea to block off a period of time to complete mid-year staffings with all families served.

PREPARATIONS FOR THE MEETING

As with the initial IPP Conference, certain preparations are necessary to better insure a successful mid-year staffing. These are preparations that concern the parents, Program Manager and involved team members and consultants.

Specifically:

The Parents:

- Have participated in ongoing programming during the classes with carryover into the home via suggested activities and techniques.
- Have informally discussed events in the family and/or their child's weekly activities with the program manager and PIP staff.

The Program Manager:

- Has reviewed the child's status as documented by notes monitoring progress on all implemented behavioral objectives.
- Has reviewed the child's progress on the IPP, based on achievement or continuation of behavioral objectives.
- Has identified major trends in the child's development, and is prepared to make suggestions about the program emphasis in the coming months.

The PIP Staff:

- Have familiarized themselves with the goals and objectives stated in the IPP and are knowledgeable of the child's progress, home activities, and parent concerns.
- Are prepared to make suggestions about the feasibility of further goals and objectives in light of the child's present developmental gains and other relevant factors.

AGENDA

In conducting the Mid-Year staffing several guidelines should be followed. An Agenda may be written and given to all participants in the meeting if desired. The Program Manager is usually the person who chairs the staffing, being most familiar with the family and team. A recommended agenda follows.

1. *Introduction:* If participants are not all familiar with one another (they should be at this point) a brief introduction should be made.
2. *Explain Purpose of Staffing:* The Program Manager gives a short description of the purpose and agenda of the staffing. All participants should be encouraged to ask questions and provide input to discussion.

3. *Review Current Status and Future Needs of Infant:* The Program Manager then reviews the present level of progress on objectives already implemented from the IPP in each area of development. Input from participants should be sought. A concensus should be arrived at among parents, Program Manager and PIP staff regarding the infant's progress, present needs and continued appropriateness of stated goals and objectives, or the need to revise the IPP in any respect.

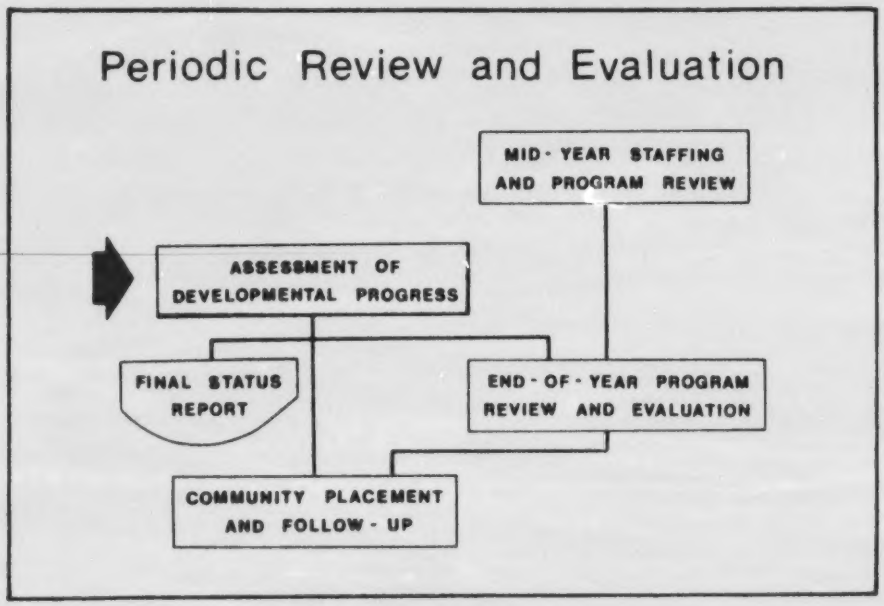
4. *Review Other Concerns:* Any other concerns of either program staff or parents should be brought to surface at the staffing. These may relate to parental feelings about how well their infant is doing, concerns over the future of the child, dissatisfaction with specific programming strategies implemented during the first part of the program, or difficulties in relating to staff. Program staff may have concerns over the parents difficulty in carrying through with suggestions at home, or may feel the need for additional assistance from team members. Program staff should try to be sensitive to the families feelings and not become defensive. If the parent's comments and concerns are met with real or imagined hostility on the part of the staff, this will strain their relationship with the program rather than ease their concerns. The key is to be attentive, concerned and supportive with parents. Working out problems will be much easier if an empathetic and non-threatening attitude is taken by staff.

FOLLOW-UP

Following the mid-year staffing, program staff should act on decisions made in the staffing. These actions should be communicated to the parents in subsequent Development Classes. There should be no question in the parents' minds that suggested changes are being made and needed services arranged.

ASSESSMENT OF DEVELOPMENTAL PROGRESS

By keeping notes on the infant's performance on specific objectives, the Program Manager and parents can note any progress that the infant makes on an ongoing basis. This type of ongoing, or formative, assessment of the infants' progress is particularly important for making any program changes needed and for providing ongoing feedback to parents throughout the year on their infant's progress. A more formal evaluation of child progress after a set period of program intervention is also helpful in providing feedback on program effectiveness.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END-OF-YEAR PROGRAM REVIEW AND EVALUATION
COMMUNITY PLACEMENT AND FOLLOW-UP

Key questions addressed in this section are:

- What is involved in assessment of developmental progress?
- How is progress assessed from the infant's objectives?
- How is progress assessed on the EMI?
- What precautions should be taken in interpreting child progress?

WHAT IS INVOLVED IN ASSESSMENT OF DEVELOPMENTAL PROGRESS?

Periodic assessment of developmental progress made by the infant participating in PIP is two-fold:

1. Assessment of individual program objectives achieved, and
2. Assessment of developmental gains made by the infant on the EMI

These data are obtained on individual infants for purposes of feedback to parents, program staff and community agencies. The assessment data can also be aggregated for all infants served in the program and progress reported in summary form for purposes of communicating overall program effectiveness to funding agencies, the community, program staff, etc.

HOW IS PROGRESS ASSESSED FROM THE INFANT'S OBJECTIVES?

Individual objectives written for the infant in the Individualized Program Plan (IPP) reflect the aims of the program in facilitating the infants' development. Therefore, the degree to which the infant achieves these objectives serves as an indication of the child's progress made in the program.

The number of objectives achieved from the beginning of the year to mid-year, and then to the end-of-the-year can be first calculated in each area of development: Gross Motor, Fine Motor, etc. Because the number of objectives written for the infant will vary depending upon the nature and severity of his/her disability or delay, it is better to report progress on objectives in terms of percentages.

> For example, at the beginning of the program year, Billy had five objectives set in the gross motor area. At the end of the year he had achieved three of these objectives. Therefore, we can say that Billy achieved 60% of his gross motor objectives. Bobby, on the other hand, less involved than Billy, achieved 6 of 10 objectives set for him in the gross motor area during his year of participation in PIP. He too, then, achieved 60% of his objectives, a desirable outcome.

Determining the percentage of objectives completed in specific areas of development is certainly no difficult task. What is difficult, however, is how to interpret the results that are achieved. For example, if one child achieves only 30% of his/her objectives in an area and another achieves 80%, does that mean that the intervention for one child was more "effective" than for the other? No, not necessarily. Several important factors enter in to interpretation of assessment results that should be reflected in your overall evaluation of the program, such as the nature and extent of the child's handicap, and the level of objectives written for the infant initially. These and other considerations in interpreting child progress are discussed on page 6-15.

HOW IS PROGRESS DETERMINED ON THE EMI?

In addition to its primary use in the Parent Infant Program--that is, as a tool for programming--the EMI can be used as a tool for assessing developmental progress from one point in time to a later point in time. Usually child progress is determined from the time of the initial assessment shortly after entry to PIP (pretest), to the end-of-the-year assessment (post-test). If an infant leaves the program during the year, the post-test is completed at the time of exit from the program. Specifically, using the EMI for pre-post evaluation of child progress involves:

1. Determining the infant's level of functioning, and
2. Determining developmental gains

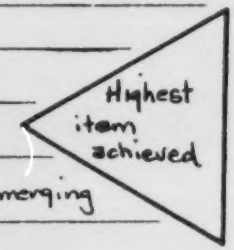
DETERMINING THE INFANT'S LEVEL OF FUNCTIONING

Following the completion of the assessment (at pre-test or at post-test), the programmer can determine the infant's level of functioning as it compares to "normal" development represented by the items on the EMI. On the EMI, developmental milestones are grouped in one-month intervals; that is, milestones indicative of 4 month functioning, 5 month functioning, etc. Determining where the infant is functionion in any one area, then, simply involves locating the highest point on the assessment which represents the infants present level of skills.

In determining the infant's level of functioning, or "developmental" age, determine the highest age category on which the infant has achieved 50% or more of the items, and after which there are at least 3 consecutive age categories in which he has not achieved 50% of the items. An example is given on the following page. In the example, the infant has achieved all of the 4 month items and two of the three 5 month items. In the 6 month category he achieved only one of three items, and achieved none in the 7 month category. In this case, then, the infant's level of function-

LANGUAGE

Item No.	DEVELOPMENTAL LEVELS AND ITEMS	DATE 10/11/79	DESCRIBE RESPONSE	DATE	DESCRIBE RESPONSE
	4 MONTHS				
4a	Laughs	+			
4b	Squeals	+			
4c	Babbles	+			
	5 MONTHS				
5a	Locates voice source	+			
5b	Locates source of sound	+			
5c	Vocalizes consonant-vowel combinations	0	emerging		
	6 MONTHS				
6a	Vocalizes to image in mirror	0	no response to image		
6b	Vocalizes to self when alone	+	(parent report)		
6c	Responds to angry tone of voice	0			
	7 MONTHS				
7a	Pats image in mirror	0	no response to image		
7b	Vocalizes eagerness at sight of bottle, breast	0			



ing, or developmental age, in the area of language can be best estimated at about the 5 month level, since this was the highest age category in which he achieved 50% or more of the items. If he had achieved one of the two items in the 7 month category and then none thereafter, the infant would be credited to one more month and would be said to be functioning at about the 6 month level. This is done so that infants will not be penalized when specific handicaps cause them not to achieve any items in a category, when the infant continues to achieve skills in higher age categories.

This procedure is followed to determine level of functioning at pre-test and at post-test in each area of assessment.

DETERMINING DEVELOPMENTAL GAINS

To aid in interpretation of the pre-post gains for each infant, it is helpful to determine the rate of developmental gain in each area by:

1. Estimating the rate of gain per month, and by
2. Comparing actual gains to estimated "previous" gains per month.

1. Estimating rate of gain per month. To determine the rate of gain made per month by the infant, first determine how many months the infant gained, developmentally, from pre-to post-test. For example, if the infant's developmental age on the EMI was estimated at 6 months in the gross motor area at pre-test and at 12 months at the time of post-test, his gain was 6 months from pre-to post-test.

Once actual months gained is determined, the rate of gain, or gain per month, can be estimated. The rate of gain per month is computed by dividing the actual months gained between testings by the number of months between testing. This provides an estimate of the degree to which a normal rate of gain is achieved (the normal rate of gain being 1.0 months growth per month).

2. Comparing actual gains per month to previous rate of gain. To aid in interpretation of the actual gains per month made by the infant in any area, we can compare this to the estimated rate of gain that the infant experienced prior to entry into the program. How is this rate of gain estimated? It is derived from the infant's initial degree of delay at pre-test. This is done by dividing the child's developmental age at pre-testing by his chronological age. This ratio can be used to estimate the rate of growth per month for a given child within his/her own chronological age span. For example, if a child at a chronological age of 12 months has a developmental age of 7 months (5 months delay) in a particular area of development, an estimate of the child's previous growth rate may be derived by dividing the child's chronological age (12 months) by his developmental age (7 months).

It might then be assumed that over 12 months the child progressed, on the average, .6 months each month. It is important to note that this is not an accurate measure of rate of gain in that many factors may determine the particular degree of delay at any point in time, e.g., young infants may develop with only minor delays until a later age level where a higher density of skills may normally be expected to emerge.

SUMMARY

In summary, to determine rate of gain made by an infant in a developmental area:

1. Determine actual months gained from pre-to post-test. For example:

   12 mos. - 6 mos. = 6 months gain = actual months gained

2. Determine rate of gain per month by dividing the actual months gained by the number of months between pre-and post-test. For example:

   $\frac{6 \text{ mos.}}{8 \text{ mos.}} = .75$ *months per calendar month gained (rate of gain)*

3. Estimate previous rate of gain based on infants delay at pre-test by dividing the infant's developmental age (DA) at pre-test by his cronological age (CA) at pretest. For example:

   $\frac{DA}{CA} = \frac{6 \text{ mos.}}{12 \text{ mos.}} = \frac{1}{2} =$ *.5 mos. per month gain*

4. Compare the previous rate of gain with the rate of gain while in the program. In the example given above, the infant's rate of gain while in PIP (.75) exceeded that which was experienced prior to entry to PIP (.5).

The table on the following page provides an organizational framework for determining developmental gains made by infants on the program. Although only three areas are shown, the same data can be presented for all areas of development. Also as shown in the table, it may be helpful in organizing and reporting child progress data to do so in terms of type and severity of handicapping condition. While there are still many individual differences between children within categories, such grouping may prove helpful in interpretation of the gains.

Table 25. DEVELOPMENTAL PROGRESS OF CHILDREN IN PIP FOR 6 MONTHS OR MORE: DOWN'S SYNDROME, 1977-1978

CHILD IDS/ SEVERITY	CA at Time of Pre-Test	Mos. Between Pre-Post Test	DEVELOPMENTAL GAINS BY AREA											
			Perceptual/Fine Motor			Cognitive			Communication			Gross Motor		
			Mos. Delay at Pretest	Months Gained (a)	Actual Gain/mo. (previous gain) (b)	Mos. Delay at Pretest	Months Gained	Actual Gain/mo. (previous gain)	Mos. Delay at Pretest	Months Gained	Actual Gain/Mo. (previous gain)	Mos. Delay at Pretest	Months Gained	Actual Gain/Mo. (previous gain)
Moderate (n=5)					(c)									
A003	19 mos.	7	8	7	1.0 (.6) *	5	5	.7 (.7) *	6	2	.3 (.7)	11	.5	.1 (.4)
A005	15 mos.	7	7	9	1.3 (.5) *	6	7	1.0 (.6) *	3	3	.4 (.8)	8	4	.6 (.5) *
B008	8 mos.	7	1	6	.9 (.9) *	0	7	1.0 (1.0) *	1	6	.9 (.9) *	0	4	.6 (1.0)
B010	9 mos.	9	5	8	.9 (.4) *	3	3	.3 (.7)	4	7	.8 (.4) *	5	6	.8 (.4) *
B022	2 mos.	4	2	2	.5 *	0	4	1.0 (1.0) *	0	1	.3 (1.0)	0	4	1.0 (1.0) *
Means	11	7	5	6	.9 (.6) *	3	5	.7 (.7) *	3	4	.6 (.7)	4	4	.6 (.6) *
Severe (n=2)														
A007	28	5	18	3	.6 (.4) *	16	3	.6 (.4) *	17	0	0 (.4)	22	1.0	.2 (.2) *
B023	10	4	6	3	.8 (.4) *	4	1	.3 (.6)	3	.5	.1 (.7)	5	1.5	.4 (.5)
Means	19	5	12	3	.6 (.4) *	10	2	.4 (.5)	15	.3	.1 (.2)	14	1.3	.3 (.3) *

(a) From pre-test to post-test
(b) Actual gain per month is computed by dividing the actual months gained by the number of months between pre-and post test. Expected gains are given in parentheses and are derived from the child's initial degree of delay by dividing the developmental age in months (the child's CA-mos. delay at pretest) by chronological age in months at time of pre-testing.
(c) An asterisk indicates that the actual gains/mo. equal or exceed previous gains/mo.

WHAT PRECAUTIONS SHOULD BE TAKEN IN INTERPRETING CHILD PROGRESS?

Determining progress made by infants by using the methods described above is a fairly straightforward process. We can easily say that the infant gained 5 months developmentally, or that he/she achieved 80% of his objectives. What these figures mean, however, is much more difficult to determine. There are a complexity of factors which come in to play when trying to answer questions such as: Did the intervention provided have an effect? Did the infant make progress above that which would have been experienced if he/she had not been in the program? These are questions for which there are no definitive answers. We do not know what would have happened if the child were not in the program. Therefore, it is important to interpret gains made by the infant with extreme caution. In doing so the following considerations should always be made and should flavor the interpretation of progress assessed for any infant in the PIP.

LIMITATIONS OF THE ASSESSMENT TOOLS

Know the limitations of the tools used in assessing progress. Developmental gains are derived in most cases from assessment tools that are not standardized and/or are often not sensitive to the very small increments of developmental change often evidenced by more severly handicapped infants. Remember--most assessment tools are designed for normally developing children. In many cases, progress is seen by programmers in areas that are not assessed.

NATURE AND SEVERITY OF THE INFANT'S DEVELOPMENTAL PROBLEMS

In interpreting developmental gains made by infants, it is always necessary to give primary consideration to the nature and severity of his/her developmental problems, or handicap. This is a very individualized process. For each infant, past history, prognosis, past development, and nature and severity of delay will vary -- even within similar categories of disability, e.g., Down's Syndrome or Cerebral Palsy. Very minimal progress may be significant for an infant that is severely multiply handicapped; an infant who may be expected to regress in his development. Also, patterns of development that are noted may deviate from the "normal" sequence seen in infants without identified disabilities. On the other hand, we might expect that an infant with Down's Syndrome, who is slightly delayed during the initial months of his life, to progress on a similar course with normal development, only at a slower rate. It is clear that interpretation of child progress must be done on an individual child basis.

APPROPRIATENESS OF OBJECTIVES

As discussed above, the percentage of objectives achieved by the infant throughout the year in the program can be used to judge progress. In fact, a more accurate description of progress made by an infant can be made from achievement of individualized objectives, than can be made from results of a developmental assessment. There are, however, limitations

here too. Objectives are only as good as they are written. If written with careful consideration of the infant's present level of functioning, they should reflect even the smallest of gains made. However, if written too high for the infant, progress may unfortunately proceed undocumented and possibly unnoticed by program manager and parents.

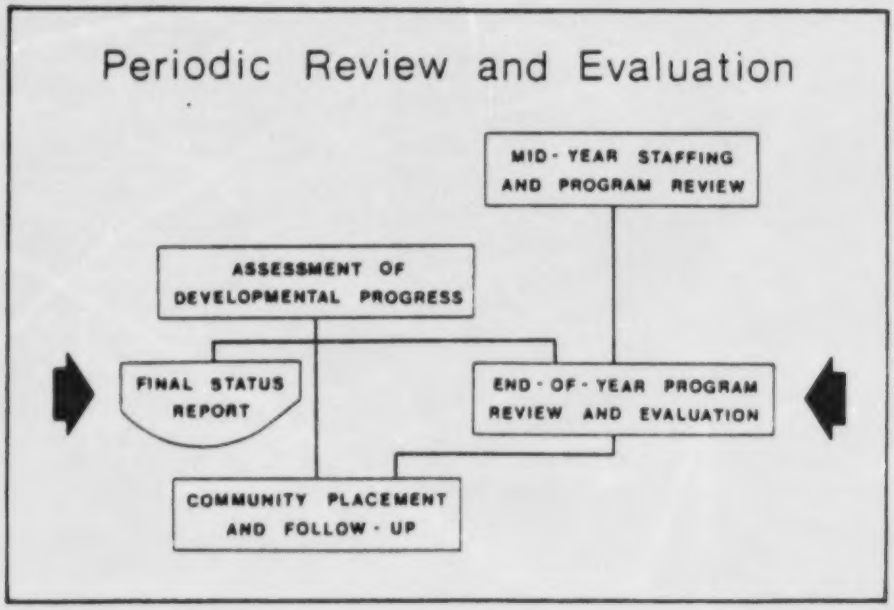
PROGRAM EFFECTIVENESS VS. CHILD PROGRESS

Finally, it is naive to judge the program's "effectiveness" in terms of child progress alone. Traditionally, in educational programs for the handicapped, progress made by the participating children was the primary, and in many cases the only, indication of the success or failure of the program. With the downward extension of program services for the birth to three population, it is even more appropriate to go beyond child progress in assessing program effectiveness--especially when parents are involved. Benefits to the infant should certainly not be dismissed; however there are other groups upon which the program is designed to impact, particularly the family and the community.

In a model such as PIP, it is important to look beyond the progress of the infant and assess the benefits to the parents. This seems obvious since the primary focus is on the parent. PIP program goals are aimed at assisting parents in effectively facilitating their infants development, at providing information and support, and at fostering positive parent-infant relationships. All of these goals can be accomplished in the absence of significant gains made by the infant! That is, the infant's development may be severely limited by the nature of his disability; but, the parent(s) may grow in their ability to interact with their infant and in their ability to cope with his/her handicap.

END-OF-YEAR REVIEW AND EVALUATION

At the end of each program year, program staff should review and evaluate their efforts with the families so that these accomplishments can be communicated to others, i.e., parents, physicians, community agencies.


Periodic Review and Evaluation
MID-YEAR STAFFING AND PROGRAM REVIEW
ASSESSMENT OF DEVELOPMENTAL PROGRESS
FINAL STATUS REPORT
END-OF-YEAR PROGRAM REVIEW AND EVALUATION
COMMUNITY PLACEMENT AND FOLLOW-UP

Key questions addressed in this section are

- What is evaluated at the end-of-the-year?
- What is involved in evaluating child progress?
- What is involved in evaluating parental satisfaction and change?
- How can program impact on the community be evaluated?
- How are results of the end-of-year review communicated to others?

WHAT IS EVALUATED AT THE END-OF-THE-YEAR?

The end-of-year evaluation should address, at minimum, child progress and parental evaluation of the program. Other areas of program impact may also be evaluated if so needed or desired by the program, including impact on the community.

WHAT IS INVOLVED IN EVALUATING CHILD PROGRESS?

Assessment of child progress has been covered in the previous section in detail. Briefly, at the end of the program year, developmental gains can be assessed for each infant in each area of development. This is based on pre-post assessments on the EMI and on the percentage of individual objectives achieved. This data can be organized and presented in summary form to communicate progress made by all children served. An example of how group data can be organized is presented on page 6-14.

WHAT IS INVOLVED IN EVALUATING PARENTAL SATISFACTION AND CHANGE?

The feedback obtained from parents on various aspects of their participation is also obtained at the end-of-the-year and can be indicative of program impact on parents. A PIP End-of-Year Parent Evaluation is provided on the following pages. The evaluation addresses parental satisfaction with program managers, the parent group, and the overall program. It also inquires into the parents' perceptions of how the program has benefited their infants and themselves.

HOW CAN PROGRAM IMPACT ON THE COMMUNITY BE EVALUATED?

Program impact on the community can be evaluated in several ways, depending upon the nature of the program's contact with the community, including:

PROGRAM VISITATION

The number and type of persons visiting the program during the year can give an indication of program visibility and awareness in the community.

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1580 Cannon Drive
Columbus, Ohio 43210

END-OF-YEAR
PARENT EVALUATION

COVER LETTER

Enclosed is the End-of-the Year Parent Evaluation of the Parent Infant Program. The evaluation is designed to obtain needed feedback on program activities from its primary participants -- parents!

The information that you provide on the evaluation will assist project staff in making decisions regarding next year's program operations. For this reason we are asking that you complete the evaluations and return them to us in the enclosed stamped return envelope. I have enclosed two forms to be completed separately by each parent.

As we are now gathering evaluative information to include in this year's final report to our funding agency, we would appreciate your response within the next two weeks.

If you have any questions regarding the evaluation, please don't hesitate to call us at 422-5176.

Thank you for your continued responsiveness.

Sincerely yours,

Linda Wnek, Coordinator
Parent Infant Project

Enclosures

LW/lmc

END-OF-YEAR

PARENT EVALUATION

Person completing form:

__ Mother
__ Father
__ Other

PLEASE RESPOND TO EACH QUESTION ASKED BELOW. BASE YOUR RESPONSES ON PROJECT ACTIVITIES CARRIED OUT DURING YOUR PARTICIPATION IN THE PROGRAM.

I. PROGRAM MANAGERS

1. How satisfied were you with your Program Managers:

	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied
a. Knowledge of your child's development?	☐	☐	☐	☐
b. Ability to relate to you?	☐	☐	☐	☐
c. Ability to relate to your child?	☐	☐	☐	☐
d. Ability to answer questions concerning your child?	☐	☐	☐	☐
e. Attitude & expressed interest?	☐	☐	☐	☐
f. Ability to identify & write appropriate program goals, objectives & activities?	☐	☐	☐	☐
g. Ability to demonstrate & provide rationale for suggested home activities?	☐	☐	☐	☐
h. Ability to involve you in program planning for your child?	☐	☐	☐	☐

2. Comments or Suggestions regarding your Program Manager _____

_____

_____

_____

II. PARENT GROUP

1. Do you feel that your initial expectations and goals for the Parent Group were met? ☐ Yes ☐ Somewhat ☐ No

   Please explain: _____

2. Did you feel that the Parent Group provided:

   a. Needed support? ☐ Yes ☐ Somewhat ☐ No

   b. Needed information? ☐ Yes ☐ Somewhat ☐ No

   Please explain: _____

3. What did you like about the Parent Group? _____

4. How might the Parent Group be improved upon? _____

III. OVERALL PROGRAM

1. Indicate your satisfication with the Parent Infant Program in the following areas:

	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied
a. Involving you as a parent	☐	☐	☐	☐
b. Orientation to the program	☐	☐	☐	☐
c. Administration & use of the initial assessment	☐	☐	☐	☐
d. Programming for your child (writing objectives in areas of need)	☐	☐	☐	☐
e. Time allotted for parents to work with professional staff (first Hr.)	☐	☐	☐	☐
f. Communication between parents & staff	☐	☐	☐	☐
g. Identification & coordination of needed services for your child (e.g., feeding, audiology evaluations, etc.)	☐	☐	☐	☐
h. Meeting parents needs for information & support	☐	☐	☐	☐
i. Meeting needs of your child (overall)	☐	☐	☐	☐
j. Parent Group (overall)	☐	☐	☐	☐
k. Considering parent's priorities & concerns for child in programming	☐	☐	☐	☐

2. Do you feel that your expectations of the Parent Infant Program were met?

☐ Yes ☐ Somewhat ☐ No

Please explain: _____

_____

_____

_____

_____

3. Do you feel that your child has benefited from participation in the program?

☐ Yes ☐ Somewhat ☐ No

Please explain _____

_____

_____

4. Do you feel that you have benefited from your participation in the program?

☐ Yes ☐ Somewhat ☐ No

Please explain _____

_____

_____

_____

5. What do you like most about the Parent Infant Program? _____

_____

_____

_____

_____

6. How might the Program be improved upon? _____

_____

_____

_____

_____

7. Other comments, suggestions regarding the Parent Infant Program:

- 4 -

REFERRALS

The number and types of referral sources may also provide information on program awareness in the community, particularly the medical community. Are an increasing number of referrals being obtained from health professionals in the community at younger ages?

TRAINING AND EXPERIENCE

Does the program have volunteers from the community? Are these persons who are expanding or developing skills that can be used in other settings in the community with other families? If so, impact has been extended beyond those families served in the program.

COMMUNITY SUPPLEMENTAL SERVICES

Supplemental services needed by and arranged for the families served in PIP are often obtained in the community. Contacts with community agencies, physicians and institutions regarding services to families often increase community awarenesses of program activities.

Thus, the number and nature of community contacts made during the year by program staff should be documented and included in the final program evaluation.

HOW ARE RESULTS OF THE END-OF-YEAR REVIEW COMMUNICATED TO OTHERS ?

The evaluation of progress made by the infant during the year is often of interest and benefit to community agencies and physicians. Therefore, an end of the year Final Status Report is written which communicates:

- Duration of participation in the Program
- Goals and objectives set and achieved during the year
- Developmental gains made on the EMI
- Supplemental services received
- Other changes observed in family or parents
- Future status of the family, i.e., placement and follow-up

A sample Final Status Report is given on the following page. The Final Status Report is then sent to the physician(s) and agencies with whom the program had initial and ongoing contact throughout the year. Additionally, this information may be forwarded to a community program in which the infant will be enrolled. A copy is also provided to the family for their records of accomplishments while in PIP.

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PARENT INFANT PROGRAM

FINAL STATUS REPORT

NAME: Carey
D.O.B. 2/2/78

Date of Report: June 15, 1979

Carey, age 16 months, with a diagnosis of Down's Dyndrome, has been enrolled in the Parent Infant Project since October 4, 1978, and will continue throughout the summer sessions. Both parents have attended the program regularly with other family members attending on a frequent basis. Carey receives considerable attention and stimulation from all family members. The family is specifically concerned with Carey's gross motor and language development and have initiated many home activities in addition to the program's suggested activities. Carey's progress in the major programming areas is certainly enhanced by the cooperative and enthusiastic efforts of all family members and the weekly visits of a Fair County home trainer.

Consultations were provided by the following disciplines: April 3, Physical Therapy (observation of Carey's motor skills), and April 10 and 17, speech therapy suggested home activities after evaluation using the Environmental Prelanguage Battery. Carey's developmental status was re-assessed on May 15th.

Carey has made consistent progress in all developmental areas during the program year, especially in gross motor, fine motor and communication skills. Overall, developmental abilities approximate that of a 12 to 15 month-old child. Carey's rapid progress and near age appropriate performance in all developmental areas is certainly in part attributable to the loving, consistent and creative efforts of her entire family.

In the gross motor area, Carey currently will stand independently for approximately 30 seconds, assume a standing position from sitting and cruise for more than 30 feet, surpassing the final target goal of standing. Her equillibrium reactions and trunk rotation are good both in sitting and standing positions but she tends to fall from standing rather than sitting down.

Carey displays good thumb opposition and a very adequate pincer grasp. She consistently uses her index finger for probing but is not yet pointing at objects to indicate her wants.

In the area of communication, Carey has surpassed the original programming goals of simple motor imitation, simple consonant vowel imitation, and playing simple games. Carey displays a considerable amount of motor imitation, clapping, tapping head, knees, putting blocks in a container, etc. Vocal imitation of simple consonant vowel sounds is inconsistent but Carey has many such sounds in her repertoire, ma-ma, da-da, na-na, ba-ba, etc. Carey also vocalizes the words ball, baby, and book frequently when presented with the appropriate objects with their verbal labels. She has also given the verbal label inconsistently to obtain a desired object. Carey also correctly discriminates between several paired objects on request; further demonstrating her receptive skills. Her functional play skills are very adequate, as indicated by her performance on the Environmental Prelanguage Battery.

In the area of cognition, Carey has achieved original goals set in the areas of imitation, object permanence, causality and play. In addition, she currently will look at objects when told to "look", and follow simple directions such as "Carey, take the car". She is beginning to gesture for desired objects such as for a drink but does not yet point at desired objects. Carey demonstrates an ability to discriminate family members when told, "Carey, look at Kathy, etc.".

Carey has very adequate self-help skills feeding herself using her fingers and a spoon with spillage. Her diet consists primarily of table foods. She drinks from a cup independently and has met all original goals set for this area.

Carey will continue with the Parent-Infant Project monthly during the summer. Program objectives will continue to focus on:

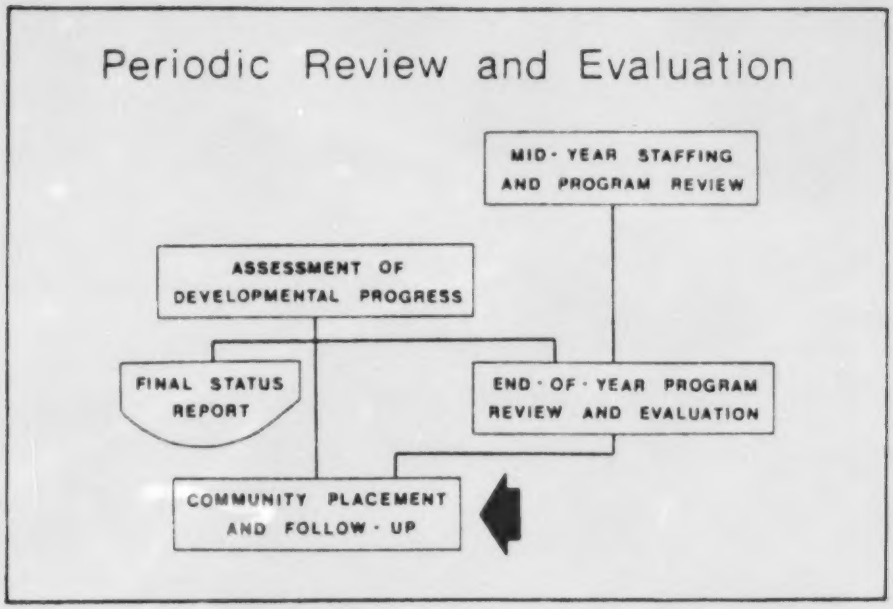
1. Improving balance and equillibrium responses in standing.
2. Development of an adaptive means of changing from standing to sitting position.
3. Walking independently.
4. Coordination of fine motor skills between hands.
5. Refinement of spoon feeding to reduce spillage.
6. Encourage pointing to objects to indicate desire.
7. Ability to point to familiar objects or people on request.
8. Use of approximations of verbal labels to obtain desired objects.

In the fall, the family will continue to work with the home-based specialist, Jean Doe, in Fair County and plan to participate in the Environmental Language program at Nisonger Center.

Bettianne Greene, O.T.R./L.
Client Services Coordinator

BG/lc
7/12/79

COMMUNITY PLACEMENT AND FOLLOW-UP


Periodic Review and Evaluation
MID-YEAR STAFFING AND PROGRAM REVIEW
ASSESSMENT OF DEVELOPMENTAL PROGRESS
FINAL STATUS REPORT
END-OF-YEAR PROGRAM REVIEW AND EVALUATION
COMMUNITY PLACEMENT AND FOLLOW-UP

In this section the following key questions are addressed:

- What is PIP's role in community placement?
- How can PIP facilitate the family's transition to a new program?

WHAT IS PIP'S ROLE IN COMMUNITY PLACEMENT?

When a family is ready to leave the Parent Infant Program to enter a new program, there are several ways that the Program Manager and other PIP staff can be of assistance.

DETERMINE "READINESS" TO LEAVE PIP

First, the decision to leave PIP must be made. This decision may be one which is made by the parents independently or together with the PIP staff. At the end of each program year, or at other points in the program, the program staff should discuss the family's continuation in PIP. Several factors should enter into whether the family continues with PIP or finds a new program in the community.

Age and/or developmental level of the infant. The PIP is designed for infants. It is also designed for parents who are in the initial stages of dealing with the circumstances of having a child with developmental problems. The program is definitely parent focused, in that the parent is the primary caregiver and facilitator of early growth and development. As the child grows out of infancy (e.g., around 2-3 years) and can benefit from a more intense child-centered program, other program options that meet these changing needs should be considered. Much may depend upon the severity of delay of the child and on parental attitudes regarding their continued involvement in their child's programming.

Parental Needs. Consideration must also be given to the needs and desires of the parents. Parents may, after a given amount of time as the infant's primary teacher and playmate, feel that they would like for their child to receive more direct contact with others in a classroom setting. The parent(s) may feel the need to change their role to a supportive teaching role rather than the central role that they assumed while in PIP. Also, parental needs for the initial support and information may have been fulfilled by PIP. Parental feelings regarding leaving the program should be discussed and should definitely be a primary consideration in determining their readiness to leave PIP.

Other Available Programs. The parents may feel that they have "outgrown" PIP due to the changing needs of their infant, but may still remain in the program for lack of other appropriate programs in the community. In such a case, the family would continue to be served by PIP.

ASSIST IN FINDING APPROPRIATE COMMUNITY PLACEMENT

PIP staff should work closely with the family in finding the best possible option for future programming for the child.

Present Program Options. In most cases program staff will know what exists in the community that is appropriate for the child. These program options should be presented to the parents and pros and cons discussed.

Visit Appropriate Programs. The parent(s) should plan to visit the programs in which they are most interested. Program staff can assist the parent(s) in setting up site visits and talking with the appropriate agency personnel. Ideally, the Program Manager, or other staff working with the parent(s),

should accompany the parent(s) on the visit. The program staff, being more familiar with programs for children may be able to ask questions that will provide information that they know that the parents will need in their decision making.

Discuss & Select Most Appropriate Option. Finally, programs visited should be discussed with the parents. Again, advantages and disadvantages should be weighed for each option considered. Factors such as transportation, cost, curriculum, hours and amount of parental involvement should be considered. Hopefully, one program will meet the family's needs better than others and a decision to enter the program made.

HOW CAN PIP FACILITATE THE FAMILY'S TRANSITION TO A NEW PROGRAM ?

Once a program has been selected by parent(s) and staff, all efforts should be made to make the family's transition into that program as smooth as possible. Many times parents will feel anxious about entering a new program and about leaving a familiar one. This is observed particularly in "first programs" such as PIP, where the family has worked closely with the staff and has come to depend on them and trust them as friends. A new program presents new unknowns and may give rise to new anxieties in the parents. Therefore, it is important to be supportive and helpful in this final phase of working with the family.

By taking an active interest in locating the "right" program for the family, the program manager has already shown his/her interest and concern over the future of the family. Other steps can also be taken to ease the transition.

Contact the new program. A call to or visit with the person who will be working with the family in the new program--before the family enters--should be helpful to both the family and to the new program. Having talked with the new program, the Program Manager may be able to provide information to the parent(s) regarding the new program's plans for the child upon entry. Initially, the parents may feel more comfortable asking questions to a familiar person in PIP than to the new program staff. Also, in talking with the new program, initial information can be personally conveyed regarding the family, the child and the parents. Any concerns that parents may have expressed can also be addressed and hopefully resolved prior to their entry.

Provide written documentation of past progress. In addition to any information that is provided at the time of the initial contact(s), the Program Manager should arrange to forward any data to the new program that will be helpful in programming for the child in the new setting. The new program should be asked what they would like to have. At minimum, the child's IPP and the Final Status Report should be forwarded. Other data may include

the child's supplemental service record, objective progress notes, home activities and general progress notes. Of course, anything sent should be a copy and should be done so under full consent of the parent(s).

Provide Periodic Follow-up. If time and effort is put into assisting parents in finding the right program for their infant and in providing needed information to the new program prior to and upon entry in the program, then the Program Manager can feel satisfied that he/she has aided in the family's program transition. It is, however, a good idea (and a good "community" gesture) to contact the program at least once after a period of time. Any further assistance to the family or to the new program staff can be offerred at this time. A call to the family might also be made to inquire into their satisfaction with the new program.

* * * * * * * * * * * *

APPENDICES

SELF EVALUATION

FOR THE PROFESSIONAL WORKING WITH PARENTS

In working closely with a family in PIP it is helpful to evaluate your own attitudes and behavior on an ongoing basis. An honest evaluation of yourself using the following questions will hopefully lead to improved rapport and interaction with parents.

- Are you aware of how the parent might be feeling and how these feelings and anxieties may interact with your efforts to work cooperatively with the parent and child? Do you react personally and negatively to parental anger, depression, denial?
- Are you aware of the parents' expectations and values regarding early intervention and the development of their child? Have you communicated your expectations to them?
- Have you truly involved parents as part of the team? Is there "visible" evidence that you have incorporated parental priorities in the child's programming? Have you communicated <u>your</u> priorities?
- Are you competing with parents?
- What is the shape of your self-concept? Are you talking "down" to parents? Do you feel that <u>you</u> are the authority? Do you use unnecessary jargon? Do you feel that you have all the answers? Are you intimidating? Do you feel superior to parents?
- Do you interact with parents based on what they say they need <u>or</u> what "you" think they need?
- Do you provide support and encouragement?
- Do you harbor preconceived notions, destructive stereotypes and negative expectations that might interefere with your relationship with the parents and the child?
- How open is your interaction with parents? Do you share all <u>relevant</u> information that is the basis for planning and decision making?
- Do you ever ask parents for help, suggestions? Do you recognize and draw upon parental skills and experience?
- Do you look for, emphasize, and reinforce positive parenting skills rather than always focusing on what the parent <u>doesn't</u> do?

DISCIPLINES ON A TEAM

Home Based Specialist

- background in child development and handicapping conditions
- expertise in providing counseling and support to parents

Language Specialist

- expertise in communication skills, including social and cognitive prerequisites, and development of receptive and expressive language.

Nursing

- background in normal child growth and development
- expertise in the area of self-help skills
- knowledgeable in areas of infant health and illness

Occupational Therapy

- background in normal growth and development, and patterns of abnormal development
- understanding of family dynamics
- specialized techniques in developing self-help skills, including feeding
- assessment and specialized techniques for neuromuscular and sensory integrative skills (ability to take in and use information for appropriate responses)

Physical Therapy

- assessment of child's neuromotor development
- expertise in positioning and handling aimed at normalizing muscle tone and promoting development of normal pattern of movement
- knowledge of techniques to prevent or alleviate development of skeletal or orthopedic problems which sometimes result from abnormal muscle tone and patterns of movement.

Psychology

- knowledge of normal child development from a cognitive, motivational and social perspective
- specialized training in child assessment and interpretation.

Special Education

- teaching approaches for children with learning problems
- devising total program for child incorporating input from various specialists

INFANT DEVELOPMENT

Assessment of the infant is typically done within five major areas of development.

Gross Motor
Fine Motor
Cognition
Language
Social

It is important to keep in mind that all areas of development are closely interrelated and that all must be viewed as a whole in order to really understand the infant. The division of these areas is to facilitate explanation and definition of development only. In reality, they cannot be divided. Each action of the infant involves some aspect of each area.

Other important points to keep in mind are that -

- development occurs at different rates in different areas.
- development is not always forward, a spurt in one area may be accompanied by a temporary leveling off or even a regression in another area.

The following provides a description of skill development within each developmental area during infancy.

GROSS MOTOR DEVELOPMENT

Gross Motor Development refers to a child's spontaneous activity which enables him to move and changes him from a primarily horizontal to a vertical or upright being. It covers the transition from early reflex activity (automatic postures or movements over which the infant has little control) to more advanced voluntary functional posture and movement. Some of the major milestones involved include:

- gaining control over position of the head
- rolling
- sitting
- crawling (on tummy)
- standing
- creeping (on hands and knees)
- walking

FINE MOTOR DEVELOPMENT

Whereas gross motor ability enables the infant to move about so that he can explore, it is an infant's fine motor skills which are involved in his actual manipulation of his environment. This area covers not only the refinement of the muscle control of the arms, hands, and fingers, but also deals with the development of the infant's sensory and perceptual skills, most obviously vision. Some of the major skill areas involved include:

- focusing eyes on people and objects
- reaching out for things he sees
- learning to grasp and handle objects of different sizes and shapes
- manipulating objects so as to explore and handle them in a number of different ways

COGNITIVE DEVELOPMENT

Cognitive Development refers to an infant's thought processes which are involved in his "learning to learn", or in learning how he can control his environment or how he can problem-solve. Increasingly sophisticated cognitive skills enable the infant to apply abstract mental concepts to objects and to events that he sees happening in his environment. Some of the major concepts involved include:

- exploration - discovering all of the possibilities of qualities which characterize a particular object or situation (for example, blocks can be banged, thrown, stacked, etc.)
- self-awareness
- functional play - using a toy for its intended purpose, such as shaking a bell, rolling a ball or pushing a car
- object permanence - learning that people and objects exist even when they can't be seen
- cause-effect - understanding how a particular effect is produced and learning to produce it yourself
- means-end - discovering strategies or actions that will lead to a desired goal through problem-solving, for example pulling a cloth to attain a toy that is out of reach

LANGUAGE DEVELOPMENT

This area is probably more accurately referred to as the development of communication. It begins very early on with touch and hearing - the parent holding the infant in a very secure way and talking very lovingly, the infant relaxing and calming in response and later maybe even smiling and cooing. The receptive language, or what the child understands, comes before the expressive language, and actually provides the foundation for the child to learn to verbalize his needs and wants and to talk. The developing infant will understand much more than he/she is able to express. This helps to explain why a gap of several months often exists between all of that talking and stimulation you give your infant and his later verbal response. All of the senses and the cognitive skills noted earlier are very closely involved. Some of the major skill areas include:

- crying to communicate that his needs, that is,that he's sleepy, hungry, wet, or needing some loving
- relaxing and later cooing or chuckling to express satisfaction, pleasure or joy
- babbling or playing with sounds
- imitating gestures and actions seen and using these to express wants and needs
- making specific and meaningful sounds for different wants and needs
- imitating new sounds heard (usually delayed)
- beginning of speech as we commonly think of it, first in single words, then in two-word phrases and so on

SOCIAL DEVELOPMENT

Probably the most basic of all five areas of development, deals with the development of the infant's unique personality or temperament and the way he faces the world and his daily life situations. Major skill areas involved include:

- developing a sense of well-being, feeling of love and trust between the infant and his parents.
- developing eye contact between infant and parent
- developing and expressing different feelings and emotions
- differentiating parents from strangers, often shown by stranger anxiety, or the fear shown by a baby at approach of a stranger
- developing attachment to parents, often shown by separation anxiety or fear a child feels when separated from parent or primary caregiver.
- developing a sense of independence, when an infant "tests his wings", or tires out his new skills and the effects he can have on his environment
- developing a sense of cooperation, both with adults and with other children
- developing a sense of competence - confidence infant develops in self that he can have an effect on his world, which is fostered initially in the secure relationship with his parent(s).

SUMMARY

Now that we've taken infant development, broken it down and analyzed "its" different areas, perhaps it will help to look at it as a whole and to summarize its major goals and the methods for achieving these goals:*

A. Goals of a Baby's Development

1. Learning to trust and to enjoy being with people.
2. Learning to influence the environment.
3. Achieving a sense of self-confidence and self-esteem.
4. Learning to enjoy new experiences, and to enjoy the process of learning itself.
5. Attaining skill in touching, holding, and moving.
6. Understanding the qualities of objects, how things work, how to use objects as tools, how to plan, and how to make a plan work.
7. Learning to communicate with people through gestures and words.

B. Basic Requirements for Achieving These Goals:

1. Loving and responsive people who devote time and attention to understand the baby's needs and who meet the baby's needs in reliable and effective ways.
2. Opportunities to have an effect on the environment, including objects that change as a result of being manipulated by the baby.
3. Exposure to varied, stimulating, and challenging experiences.
4. Encouragement of curiosity, exploration, and play.
5. Examples of skills the baby is trying to learn, such as fitting objects together, and making speech sounds.

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* from "The Meaning of Infant Development", page 19, Infant Development Guide-You and Your Baby - The First Wondrous Year - Johnson & Johnson Baby Products Company, 1978.

ANNOTATED BIBLIOGRAPHY
OF
SELECTED RESOURCES

RESOURCES FOR PROGRAMMING

BABY EXERCISE BOOK

Author: Levy, Janine (Dr.)
Pantheon Books
A Division of Random House
BOX 15570
Baltimore, Maryland 21263
Cost: $7.82

This book serves as a good guide for parents who want to facilitate motor activity in newborns and infants. The activities and exercises are staged into four groups, according to age. The book discusses briefly motor development and materials which are often used. It has many nice photographs throughout demonstrating some exercises.

BABY LEARNING THROUGH BABY PLAY

Author: Gordon, Ira J.
St. Martin Press
175 Fifth Avenue
New York, N.Y. 10010
Cost: $3.95

This book is a simply written guide to games and activities that encourage growth in various areas of development. It is nicely illustrated.

CHILDREN MOVE TO LEARN

Author: Kline, Judy
The Ohio State University Research Foundation
1314 Kinnear Road
Columbus, Ohio 43212

A guide designed for; 1) assessment of selected gross motor abilities; 2) detection and identification of delays and: 3) planning and implementation of an appropriate Individual Activity Plan, using the results from the assessment in correcting the defected delays. The guide is divided into five major areas of motor abilities.

RESOURCES FOR PROGRAMMING

THE EMI CURRICULUM POOL MATERIALS

Authors: Elder, Wanda B., and Swift, John, N., Ph.D.
University of Virginia Medical Center
Charlottesville, Virginia 22901

The EMI Curriculum Pool Materials are intended for use by professionals and paraprofessionals in the fields of infant development and infant intervention and may be used in planning activities for both generic and handicapped infants. The curriculum is based on the EMI Assessment Scale, a five part, 360 item scale of typical behaviors in the infant from birth to the age of 24 months.

The curriculum consists of five major sections, each representing a major area of infant development, Gross Motor, Fine Motor, Social, Cognitive and Language.

HANDLING THE YOUNG CEREBRAL PALSIED CHILD AT HOME

Author: Finnie, Nancie R.
E.P. Dutton
New York, N.Y.
Cost: $4.95

This is an indispensable guide for parents, nurses, therapists, doctors, social workers and other persons involved in caring for the young child with cerebral palsy. The chapters offer alot of helpful information on wedges, optimal positioning techniques to facilitate the development of skills.

MOTHERS CAN HELP: A THERAPIST'S GUIDE FOR FORMULATING A DEVELOPMENTAL TEXT FOR PARENTS OF SPECIAL CHILDREN

Authors: Cliff, Shirley, R.P.T., Gray, Jennifer, O.T.R., & Nymann, Carol, M.Ed.
El Paso Rehabilitation Center
2630 Richmond
El Paso, Texas 79930
Cost: $9.50
2nd Edition 1977, 212 Pages

This book is written for therapists teaching parents of young children with cerebral palsy. The authors suggest that the materials be used as handouts for a group parent education program, and caution that physical exercises such as range of motion, should be learned under the supervision of a therapist. The book is typed double spaced, and each chapter includes questions with space for parents to write in the answers. The materials is simply presented, illustrated with line drawings, and has a very practical orientation.

RESOURCES FOR PROGRAMMING

MOTHERS CAN HELP (cont.)

About half the chapters focus on some aspect of motor functioning; positioning, range of motion, posture and locomotion, hand and arm use, feeding, and sensory stimulation. Emergency procedures for choking and seizures are included, and a short chapter deals with discipline. Systematic behavioral teaching strategies are not included.

The reader should be cautioned that the material on mental retardation is outdated.

A PRESCRIPTIVE BEHAVIORAL CHECKLIST FOR THE SEVERELY AND PROFOUNDLY RETARDED

Author: Popvich, Dorothy
University Press
Chamber of Commerce Building
Baltimore, Maryland 21202
Cost: $14.95

This volume presents a series of checklists and their applicable tasks analyses specifically designed for use with profoundly retarded children. It is the only book of behavioral checklists that is prescriptive as well as diagnostic. Encompassing the development age span of 0-3 and designed for the retarded, it can be readily be adapted for the use with any child lacking the skills that fall within the developmental range.

PROGRAM GUIDE FOR INFANTS AND TODDLERS WITH NEUROMOTOR AND OTHER DEVELOPMENTAL DISABILITIES

Authors: Connor, Frances P., Williamson, G. Gordon, and Siepp, John, M.
Teachers College Press
1234 Amsterdam Avenue
New York, New York 10027
Cost: $12.95

This program guide for the therapists, teachers, physicians, psychologists, and other caregivers working with developmentally disabled children and their parents is orginized in three parts. Part I discusses the fundamentals of a sound development program - basic assumptions, assessments, nutrition. Part II describes developmental sequences of normal and atypical children and intervention strategies. Part III presents practical application of curriculum.

READY, SET, GO TALK TO ME

Authors: Horstmeier, DeAnna S. and MacDonald, James D.
Charles E. Merrill Publishing Company
1300 Alum Creek Road
Columbus, Ohio 43216
Cost: $3.00

RESOURCES FOR PROGRAMMING

Most parents and professionals who deal with the mentally retarded or language delayed child realize the importance of language and communication in helping a child deal with the world. Ready, Set, Go: Talk to Me is designed to facilitate nonverbal skills which lead to spoken language and sequential language development.

A STEP-BY-STEP LEARNING GUIDE FOR RETARDED INFANTS AND CHILDREN

Authors: Johnson, Vicki M. and Werner, Roberta A.
Syracuse University Press
1011 East Water Street
Syracuse, N.Y. 13210
Cost: $7.95

A programmed guide for teaching developmental skills to children with retardation who are developmentally less than two years old. The guide gives specific information on behavior controls and motivation as well as ordered talks, specific objectives and activities for sensory stimulation social behavior, imitation, gross motor and fine motor skills.

TEACHING YOUR DOWN'S SYNDROME INFANT - A GUIDE FOR PARENTS

Author: Hanson, Marci
University Park Press
Chamber of Commerce Building
Baltimore, Maryland 21202
Cost: $12.95

Task analyzed activities are prompted by various levels of physical prompts: wrist prompt, forearm prompt, etc.. Includes chapters on behavior management, task analysis and developmental milestones. Detailed, easy format to follow.

ESPECIALLY FOR PARENTS (BUT GREAT FOR PROFESSIONALS, TOO)...

LET OUR CHILDREN GO

Author: Biklen, Douglas
Hyman Policy Press
P.O. Box 127
University Station
Syracuse, New York 13210

This book outlines the steps parents of children with disabilities can take in fighting for their needs. It is attractively illustrated with photographs and reads easily.

The author suggests beginning with an examination of one's own values, and discusses considerations in organizing a work group, such as identifying the goals members agree on. It identifies tactics used by those who resist change, and ways of responding to those who resist change. This book explains how to organize various types of action including: demonstrations, communications, negotiation, letter writing, community education, lobbying and organizing for school. A section on legal action predates PL94-142 and yet contains the same concepts: due process, equal protection, rights to review records.

NEW DIRECTIONS FOR PARENTS OF PERSONS WHO ARE RETARDED

Authors: Perske, Martha and Robert
GOARC
140 S. 40th Street
Omaha, Nebraska 68131
Cost: $1.95

This is a book on attitudes for parents of children who are retarded. It is divided into four sections. The first focuses on the parent, to help parents get clearer perspective on their own feelings. The next section focuses on the child, followed by the family, and then society.

The author states that it was written to offer parents help at a time when they "might be caught in a conglomerate trap of confusion, anxieties, and hurts". It is written in a personal style, attractively illustrated with Perske's charcoal drawings of children.

The chapters include: Unrealized Expectations, Weird Times, Change, Repulsion, On-theJob Learning, Relative Human Experience, Rish and Courage, Sexual Development, Family Systems, Healthy Launching Pads, and Organized Advocacy.

PARENTS SPEAK OUT: VIEWS FROM THE OTHER SIDE OF THE TWO-WAY MIRROR

Authors: Turnbull, Ann P. and Turnbull III, H. Rutherford
Charles E. Merrill Publishing Company
1300 Alum Creek Drive
Columbus, Ohio
Cost: $5.35

ESPECIALLY FOR PARENTS (BUT GREAT FOR PROFESSIONALS, TOO)...

In this book professionals who are parents of handicapped children tell their personal stories. They describe family difficulties in coping, and insensitivity and ignorance of the professionals, and the larger community. The most frequently stated complaint was professionals' failure to listen to parents, and treat them as competent adults.

Although written for both parents and professionals, the dual identity of the writers make it particularly valuable for professionals.

TO GIVE AN EDGE

Authors: Horrobin, J. Margaret and Rynders, John E.
Colwell Press, Inc.
1500 S. 7th Street
Minneapolis, Minn. 50415
Cost: $2.00

This is a readable and highly informative book written for parents. It includes personal reactions and feelings of parents, and is illustrated with photographs of children with Down's Syndrome. The emphasis is on how the parent can develop the child's skills. Chapter titles include: Dealing with Problems, Day to Day Care, Some Social Aspects of Down's Syndrome, Language Stimulation, The Importance of Play, and Looking Ahead.

FOR PERSONS WORKING WITH PARENTS....

HOW TO ORGANIZE AN EFFECTIVE PARENT GROUP AND MOVE BUREAUCARCIES

Author: Des Jardins, Charlotte
Co-ordinating Council for Handicapped Children
407 S. Dearborn
Chicago, Illinois 60605
Cost: $1.50

This booklet is written specifically for parents of handicapped children and their helpers to show them how to move bureaucracies and get better services for their children. Many of the techniques and strategies described in this booklet have been used successfully by organizations servicing mainly non-handicapped persons.

PARENTS ON THE TEAM

Editors: Brown, Sara and Moersch, Martha
The University of Michigan Press
P.O. Box 1104
Ann Arbor, Michigan 48106
Cost: $5.95

This publication serves three purposes: 1) to assist programs for young handicapped children in actively involving parents; 2) to point out to professionals and parents the various advocacy roles parents can play in securing services for their handicapped children; and 3) to remind all persons working with parents of handicapped children that the parenting of these children is a 24 hour a day job which reaches beyond school.

RIGHTS HANDBOOK FOR HANDICAPPED CHILDREN AND ADULTS

Co-ordinating Council for Handicapped Children
407 S. Dearborn
Chicago, Illinois 60605
Cost: $2.30

This handbook is intended as a reference and a guide to rights defined by Federal and State Legislation. It is not intended to be used as a law book or legal document. The handbook includes areas such as: Education, Supplemental Security Income, Social Security Income, Tax Deductions, Rights of an Institutionalized Individual, Vocational Rehabilitation, Employment and Housing.

WORKING WITH FAMILIES

Authors: Cansler, D.P., Martin, G.H., Valand M.C.
Chapel Hill Training-Outreach Project
Lincoln School
Merritt Mill Road
Chapel Hill, N.C.
Cost: $4.50

FOR PERSONS WORKING WITH PARENTS ....

This manual is designed to help recognize and improve the important role that the family plays in the handicapped child's life. The authors feel that the efforts can be magnified immeasurably by seeing the family as a unit and strengthening the support and skills of the parents, the child's first and most motivated teacher. Strategies and resources are offered in this manual to be flexibly.

WORKING WITH PARENTS OF HANDICAPPED CHILDREN

Authors: Heward, William, Dardig, Jill, and Rossett, Allison
Charles E. Merrill Publishing Company
1300 Alum Creek Drive
Columbus, Ohio 43216

The authors have presented well organized, substantive information with sufficient "how to" details to insure that the reader will be able to implement the excellent suggestions and guidelines that are offered. Topics such as adapting the home environment for accessibility, preparing baby-sitters for an exceptional child and assisting parents in planning for the future are addressed.

OTHER RESOURCES ON DOWN'S SYNDROME

AIM TO FIGHT LOW EXPECTATION OF DOWN'S SYNDROME CHILDREN

Editor: Poor, J. Jucille, Ph.D.
North Central Publishing Co.
274 Fillmore Avenue
St. Paul, Minnesota 55107
Cost: $3.95

This book is a collection of articles concerning Down's Syndrome, assembled by an early intervention project. It contains personal experiences of project participants and many photographs. Information on developmental sequences is featured. Outstanding however, is the chapter by Cicchetti and Sroufe on the relationship between the infant's emotional and cognitive development.

THE CHILD WITH DOWN'S SYNDROME (MONOGOLISM)

Authors: Smith and Wilson
W.B. Saunders Compa-y
West Washington Square
Philadelphia, Pa. 19105
Cost: $6.50

This is a medically oriented book containing a thorough presentation on the cause of Down's Syndrome, and physical characteristics throughout the child's life. The slowing of the rate of development is noted, as is the smaller brain size, as limiting factors in learning.

This book gives a limited and rather dismal picture regarding the education of the Down's Syndrome child. It conveys the impression of advocating institutional care when the children reach school age, (albeit quality institutional care:). The authors neglect to present teaching techniques which have resulted in progress made in Down's children beyond what was previously expected.

DOWN SYNDROME - GROWING AND LEARNING

Authors: Pueschel, Siegfried M., M.D., Editor, Canning, Claire D., Murphy, ann, Zausmer, Elizabeth
Sheed, Andrews & McMeel, Inc.
6700 Squibb Road
Mission, Kansas 66202
Cost: $4.95

This book is very informative and has a practical orientation. It conveys an attitude of respect and caring for handicapped children, and is illustrated with attractive photographs of children with Down's Syndrome.

The introductory chapters are written by parents. One chapter is on accessing community resources. Three chapters cover causes, characteristics and developmental expectations. Four chapters deal with teaching specific skills in early development. The emphasis is motor development: language/communication is omitted. Concerns relevant to particular later periods of develop-

ment, from nursery school years to young adulthood, are featured in the last six chapters.

Highly recommended for its comprehensiveness and practical focus.

DOWN'S SYNDROME (MONGOLISM)

Authors: Koch, Richard, M.D. and De LaCrus, Felix F., M.D.
Brunner/Mazel
64 University Place
New York, N.Y. 10003
Cost: $10.00

This comprehensive volume for both professionals and parents assesses developments in the research of Down's Syndrome. Experts in Down's Syndrome focus on prevention and diagnosis in chapters in Etiology, Chromosomal Abnormalities, Facial and Oral Manifestations of Down's Syndrome, Prenatal Detection, and FAmily Planning. Typical patterns and variations of developmental progress in Trisomy 21 and mosacicism, as well as current therapeutic approaches are described.

FIRST YEARS OF A DOWN'S SYNDROME CHILD

Author: Rietz, Elizabeth Dunkman
Special Child Publications
A Division of Straub Printing & Publishing
4535 Union Bay Place N.E.
Seattle, Washington 98105
Csot: $9.95

This book is a sensitively written journal of the experiences of one woman following the birth of her infant with Down's Syndrome. In the opening chapter she describes her despair and confusion in dealing with her infant's diagnosis. She openly discusses her ambivalence regarding the care of her child and describes her strategy for coping with these feelings. Most of the book is a chronological account of daily teaching lessons, describing routines, records, success and frustration. Activities are cognitive and fine motor tasks described in sufficient detail to be easily carried out by others.